Farringford Care Limited

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Inspection report

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Ratings

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

Overall summary

We undertook this unannounced inspection on the 12 and 16 June 2015. The last inspected took place on 23 and 28 April 2014 and the registered provider was found to be compliant with the regulations that we assessed.

Farringford Care Limited is registered with the Care Quality Commission [CQC] to provide personal care to people in their own homes. The service offers support to people living with dementia, learning disabilities, mental health conditions and physical disabilities. The service is available to people in the Grimsby and Cleethorpes area. If people wished to visit the registered provider's office there are meeting rooms available on the ground floor. There is a car park for people to use and additional on street parking.

This service has not had a registered manager in place since 13 August 2013. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'registered persons'. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered provider has allowed a person who has not applied to become the registered manager to be in day to day charge of the service. They have a title of 'project manager'. This person told us at the time of the inspection they had been there for two and a half years and had never intended to make an application to become the registered manager.

At this inspection we found a number of breaches of legal requirements which placed people at significant risk if harm. Some people had received inappropriate or inadequate care.

Staffing levels at times were inadequate. This meant that people did not receive safe care. Staffing levels reduce by fifty percent at weekends because staff had every other weekend off. There was poor staff rota management by the registered provider. Staff had zero hour's contracts which allowed them to choose when they were available to work. The registered provider was unable to cover all the calls they needed to undertake over one weekend, 29 May 2015. People did not receive safe care and treatment and were placed at risk of harm. Three people had their calls missed. One person was found on the floor when staff from another registered provider called to visit them, and two had not received their medicines. Corrective action was not taken in a timely way by the management team to help protect people. The registered provider does not have systems in place to make sure that the service provision is not affected to this level again.

Annual training had not been completed for thirty seven percent of staff. The registered provider had not ensured that this training was completed in a timely way. Therefore people being supported in their own homes were attended to by staff whose skills were not up to date. Some people received inadequate care and support which affected their health and wellbeing. Some staff used poor infection control and moving and handling techniques which placed people at risk of harm. Staff were not supported to deliver care to people safely and to an appropriate standard.

People's care records were not up to date to help inform staff of the care and support people needed to receive.

Medicines were not always handled safely. People did not always have their medicines when they were prescribed. This was because some rostered calls by staff to people in their own homes did not occur. One person had the wrong medicine patches applied. This meant that people received inadequate support with their medicines which placed their health at risk.

Staff understood they had a duty to protect people from harm and abuse. They knew how to report abuse to the local authority or to the Care Quality Commission [CQC]. However, some staff delivered inadequate care to people and not all of the required notifications had been sent to the Commission. There are twelve concerns about abuse and improper treatment which are being investigated.

The registered provider had some audits in place; however these audits had not been effective in highlighting the problems that we found during the inspection. There was a lack of management oversight into the quality of the service provided to people and incidents, accidents and complaints had not always been identified, reviewed or improvements made as a result. We concluded that the service was not well-led.

We found overall that people who used the service were at significant risk of receiving inappropriate or unsafe care. We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to: staffing, good governance, safeguarding service users from abuse and improper treatment and safe care and treatment. There were also two breaches of the Care Quality Commission (Registration) Regulations 2009 for failure to notify incidents and failure to have a registered manager in place.

Where we have identified a breach of a regulation during inspection which is more serious, we will make sure action is taken. We will report on this when it is complete. The quality rating of this service is inadequate, therefore this service has now been placed in special measures.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff training in how to protect people from abuse was not up to date. Safeguarding issues were not reported to us.

There had been significant shortfalls of staff available. There were not enough skilled and experienced staff available to meet people's needs.

The registered provider had ineffective systems in place to manage risks and ineffective policies and procedure in place.

People's care records were not up to date. Some people had received inadequate care. Poor infection control and moving and handling techniques had been used by staff. Some people had not received their calls.

Systems in place did not ensure people received their medicines safely. This placed people at risk of harm.

Is the service effective?

Inadequate

The service was not effective.

Training was not up to date and staff were not receiving effective supervision. Appraisals were not taking place.

Staff did not always monitor people's health and wellbeing appropriately. Advice was not sought timely from relevant health care professionals to help to maintain some people's wellbeing.

Is the service caring?

Inadequate

The service provided was not always caring. People told us staff were caring, they said they were treated with dignity and respect. However, 12 safeguarding investigations are currently being investigated and these include incidents of poor care and practice.

People's care calls were sometimes reallocated to other staff which broke the continuity of care to people.

Is the service responsive?

Inadequate

The service was not responsive. Staff were not always responsive to people's needs. People did not have up to date care records in place to guide staff in how to meet their needs.

The registered provider did not have up to date information in place when staff from other services had to step in to provide care to people they had not met before.

The service had a complaints policy in place, this information was given to people on commencement of the service.

Summary of findings

Is the service well-led?

The service was not well led. The service does not have a registered manager. The service lacks management and leadership to promote good standards of care and support.

The registered provider had not completed statutory notifications required by the Care Quality Commission.

Policies and procedures in place were old and were not followed by the management team. New policies and procedures had not been personalised to the service so were not in use.

There were ineffective auditing systems in place to ensure the quality of the service provided was maintained at a safe level for people. This placed people at risk of harm.

Inadequate

Farringford Care 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 checked whether the registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12 and 16 June 2015 and was unannounced. Two social care inspectors attended the service on the first day. On the second day one social care inspector attended with an expert by experience. An expert by experience is someone who has used this type of service or knows about this because their relatives have received this type of care and support.

We moved this inspection forward because we had concerns that the registered provider may not be supporting people who used the service effectively. Prior to our inspection we reviewed all the intelligence CQC had to help inform us about the risk level for this service. We found that we had received no notifications from the registered provider. We reviewed all of our information to help us to make a judgement. We attended a meeting with the Clinical Commissioning Group [CCG] and registered provider prior to our inspection where information of concern was shared with us that the registered provider had not been able to cover their contractual obligation to people over one weekend of 29 May 2015 and they had asked for help from the CCG and other providers of care.

During our inspection we visited the registered provider's office. We visited one person receiving a service in their own home. We used observation of the support the person was receiving to help us understand their experience of the service. We spoke with ten people who received a service and with six relatives by phone.

We looked at seven care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as incident and accident records and medicine administration records [MAR's]. We looked at a selection of documents relating to the management and running of the service. These included policies and procedures, quality assurance documentation and complaint information. We also looked at staff rotas and four staff files which included training records supervision and information about recruitment.

During our inspection we spoke with the project manager, Nominated Individual and with 13 staff to gain their views.

Inadequate

Is the service safe?

Our findings

We asked people who used the service if staff promoted their safety and we asked them if they felt safe with the staff. We received the following comments: "I always feel safe." "100% safe, I have two regular carers, fantastic cover with them - they are brilliant." However, one person told us their call was delayed because a member of staff's car broke down and they said, "Weekends can be a bit hectic." Another person said, "They had problems the other weekend, adult services were covering, they were late coming on the first night, should have been here 9.30pm but it was 10.15pm, got a call the next night at 10pm to say they were running late, we cancelled the call."

The relatives that we spoke with were asked if they felt the service their family member received was safe. The following comments were received: "Yes staff are pretty regular and I can trust them." and "Yes, I feel he is extra safe." However one relative said "We had one incident on 6th June weekend, we should have had 2 carers and only 1 came." They added that the staff couldn't put Mum on the commode.

Despite the positive comments we received from people we found staffing levels were inadequate at times and people were at risk. Prior to our inspection the service had insufficient staff available to provide care and support to people. On 29 May 2015 and over that weekend, the registered provider had been unable to meet its contractual obligations to people in the Humberstone and New Waltham areas. The registered provider had to inform the Clinical Commissioning Group [CCG] of this. Staff from the CCG had to step in to provide cover to some people in their own homes. This meant that staffing levels were inadequate and people were placed at risk of harm.

During our inspection we found that this situation had been allowed to occur because staff had zero hour's contracts. Staff had been allowed to state when they wished to work and had been permitted to have every other weekend off. This meant at weekends there were fifty percent less staff available to provide a service or to cover sickness and absence. On 29 May 2015 staff sickness and absence occurred in numbers that the registered provider was unable to cope with. Staffing could not be adjusted according to the needs of people who used the service. The registered provider did not determine the staffing levels they needed to have in place to guarantee that they could cover their responsibilities because they failed to take into account the number

of people using the service and their assessed needs. **This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the registered provider to take can be found at the back of this report.**

Staff we spoke with told us: "Weekends are alright, a bit chaotic- a lot of carers off sick usually weekends and bank holidays is always when this happens." "There is only half the staff on at weekends." "At weekends we get calls to pick up that are extra. Half of us are off every weekend. I pick up calls where I can. I was working this weekend [30 May 2015] I got twenty hours of calls it was manic. Clients were flexible and helped us out. It's unusual, it is the first time I had had less travelling time. They [on call staff] phoned and asked if I could do one more call- I did it. I got a letter of thanks." "Weekends can be a bit crazy. I worked the Saturday, [30 May 2015] I could not fit in anymore calls. [I was not aware of the issue]. I have had calls late in the evening to pick up calls in the morning- I could pick up calls before 8am, I am happy for them [office staff] to call. I do it if I can." The comments we received from staff confirmed that there have been constant difficulties maintaining staffing levels at weekends and bank holidays. Having a shortfall in staffing levels was not exceptional. The registered provider therefor knew that they could have insufficient staff available to provide a safe service to people at weekends and over bank holidays. **This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the registered provider to take can be found at the back of this report.**

Safeguarding training was not up to date for some staff. Staff we spoke with were knowledgeable about the types of abuse that may occur and knew what action they must take to protect people.

However, we found that the registered provider had ineffective procedures in place for protecting people from abuse. For example, during our inspection we became aware that a relative of a person who received a service had reported losing money from their home on more than one occasion. This potential abuse had not been reported

Inadequate

Is the service safe?

to us. There had been no safeguarding issues raised since our last inspection. The registered provider has not reported safeguarding issues to the Commission. **This is a breach of regulation 18 of the Registration Regulations and a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the registered provider to take can be found at the back of this report.**

We were made aware that when staff from the local authority had needed to provide care and support to people it was observed that some staff from Farringford Care Limited provided inadequate care and support. Concerns were raised that staff did not was their hands or change their gloves appropriately to protect people from inadequate infection control techniques. Staff were seen to put people at risk of harm by using an outlawed moving and handling technique called a 'drag lift'. This technique places the person at risk of friction damage to their skin and it can damage people's shoulder and arm joints.

The care files we inspected in the office had people's care information and risk assessments in place. We saw risks to people's wellbeing and environmental risks present in people's home environment were present to help to inform the staff. Risk assessments were not always in place for people relating to pressure care and tissue viability. Where risks had been identified, risk assessments were not always completed, not all risk assessments provided enough detail for staff to ensure people's safety. For example, we were informed that a person had a sore area of skin on their sacrum had no moving and handling equipment in place to prevent their skin condition from deteriorating and no up to date moving and handling plan in place. There was no record regarding the person's pressure area care. Concerns about this person's skin condition were referred to a health care professional for assessment and advice to prevent further incidence of pressure damage to their skin.

Staff told us that people had information in their care files to help guide them. However, a member of staff from Farringford Care Limited had queries about how best to assist a person when changing their position reported that they did not always feel they were listened too and reported that for one person sometimes poor moving and handling techniques had to be undertaken because they did not have the equipment or training provided to support them. The registered provider has not ensured safe care was provided for this person.

Another person did not have their medicine needs recorded on their care plan and risk assessment. Therefore staff who had not met this person before had not left inhalers by their side for them to use if they needed them. This had made the person anxious and upset. This did not ensure that the person's health and safety was protected.

Inadequate care and attention had been paid by staff regarding people's medicines. Staff we spoke with told us that they were clear about the policies and procedures in place regarding medicines. However, three safeguarding alerts were made by the CCG after the weekend of 29 May 2015 relating to medicines. One person had not received their medicines because staff had not attended their care call. This was reported by other staff who attended the person who noted that their morning medicines had not been taken. Advice had to be sought from the person's out of hours GP to protect their wellbeing. Another person had not been assisted with their medicines. The third person was found to have the wrong medicine patches in place.

People's care records and risk assessments had not been reviewed on a regular basis to ensure people received safe care. **This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the registered provider to take can be found at the back of this report.**

Inadequate

Is the service effective?

Our findings

People we spoke with said the staff looked after them and met their needs. We received the following comments; "Yes, they [staff] are cheerful - nothing is too much trouble" and "They know exactly what they are doing."

People's relatives confirmed staff effectively met their family member's needs. We received the following comments; "They [staff] help her and do what she need." "They know what his needs are."

Most people we spoke with confirmed that usually the staff attended when they were meant to and stayed the required amount of time. However, one person told us, "Last night the carer was late by half an hour, she had let the agency know but I did not get a call- this does not happen often."

During our inspection we visited one person receiving a service in their own home. We saw that the staff understood the person's needs dislikes and preferences. The person told us they praised their staff and said their needs were met. They told us how their health had improved because staff had contacted the district nurse who had their needs and treatment reassessed. New treatment had commenced and this had made a positive change to their health.

Although we received positive feedback, we also found that some people had not received effective care and support.

Some people who used the service have received inadequate care. Issues have been raised which are being looked at after being raised with the local authorities safeguarding of adults team. The issues raised include allegations of ineffective care and support, lack of attention to detail in delivering pressure area care to people, poor infection control and moving and handling techniques. Missed calls had occurred which meant people missed medicines and received an inadequate service. We are currently awaiting the outcome of these safeguarding investigations and will report upon them once they have concluded.

The registered provider's policy was to provide yearly training to all staff in a variety of subjects. These included: moving and handling, food hygiene and infection control, first aid and emergencies, health and safety at work, administration of medicines and safeguarding adults/adult abuse. However we found that some staff's yearly training had lapsed which meant some people were supported by staff whose training was out of date which placed people at risk of receiving inadequate care and support. This placed people at risk of harm because the staff's skills were not kept up to date. The person in charge of the service said, "The training systems changed in January 2015, unfortunately some training has gone over one year, there are now coursed on July 10,16,17 the week of 20-24 July and on 3,6,7 August 2015 to clear all the outstanding training. I found out last week, therefore the dates now are in the diary." This meant that some people were receiving care and support from staff whose skills and knowledge was not up to date. This places both parties at risk of harm.

Supervision provided for staff was not effective. The senior carers made unannounced visits to care staff whilst they were delivering care and support to people in their own homes. The purpose of these observations was for the senior carers to see how staff assisted people and delivered their care. They also checked that staff were wearing the correct uniform and that they were completing people's care records appropriately. Staff did not have time allocated to them where they met with the senior staff in the office to have quality time to discuss care issues or their training and support needs. Staff we spoke with said, "I had a 'spot check' last week where the senior carer comes unannounced. Uniform, phones, badges are checked and how we are dealing with service users. It is unannounced and keeps me on my toes." and "Spot checks' – they just turn up. Sometimes they are a bit of a hindrance, some service users don't like this, they have to be done." This type of monitoring care given to people has been ineffective because it has failed to highlight the fact that some staff were using poor infection control and moving and handling techniques.

The registered provider does not have suitable arrangements in place to ensure that the staff were appropriately trained and supervised to deliver care to people safely and to an appropriate standard.

Appraisals for staff were not being undertaken. One member of staff we spoke with said, "I've had an appraisal in 2013." Records showed that there had been no appraisal had taken place in the previous year or in 2015. The project manager in charge of the day to day running of the service told us that appraisals were not being undertaken.

The registered provider does not have effective systems in place to support staff. The registered provider has failed to

Inadequate

Is the service effective?

provide appropriate support, training, supervision and appraisal that are necessary to enable staff to carry out the duties they are employed to perform. **This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The action we have asked the registered provider to take can be found at the back of this report.**

We received mixed feedback from staff about how information was shared with them. Staff we spoke with told us that staff meetings did not occur. We received the following comments: "No staff meetings, we get newsletters occasionally or information from our rotas." "No meetings, no staff survey." and "No staff meetings, get a newsletter regarding updates and general information." We were informed that some meetings had occurred but mainly the registered provider communicated with staff by issuing them with information with their rotas or by office staff phoning carers to pass information to them. This system may not ensure that effective communication is maintained.

The registered provider was asked if anyone that the service supported was under the court of protection. They confirmed that there was no one currently using the service with this in place. Staff we spoke with told us they had undertaken training about the Mental Capacity Act 2005. Staff confirmed that restraint and physical interventions were not used for people who used the service. They told us people were supported by their relatives to make decisions for themselves. We saw that some people had signed some of their care records to indicate they agreed to the care they were receiving.

There was inadequate attention paid on some occasions to people's dietary needs. One person who was receiving a service had not received a call at tea time and had therefor not been given their pre made sandwich by staff. A carer from Farringford Care Limited was observed to have not washed their hands after delivering personal care to a person before attending to food preparation.

Inadequate

Is the service caring?

Our findings

People we spoke with told us they felt the staff were caring. We received the following comments: "They [staff] are very caring - no problems." "Yes, they are absolutely wonderful." We were told staff treated people with dignity and respect. However, one person said, "Some of the girls are useless, they don't talk to me and they don't ask what I want."

Relatives we spoke with said that the staff were caring. One relative said: "On the whole they are friendly, they sit and chat. Mum is always happy."

We visited a person receiving a service in their own home. We saw two care staff providing help and support this was undertaken in a professional and caring manner. The staff knew the person's needs well and spent time listening to the person's views and to their relative. They looked well cared for. Attention to detail was paid to make sure the person was comfortable and was satisfied with the care the staff had provided. One of the care staff had attended to the person for a long time, this provided continuity of care. Our observations of the interaction between the staff, the person and their relative confirmed a positive bond was in place, friendly banter occurred and the person told us they genuinely felt the staff cared about them and their relation. The staff promoted and respected the person's privacy and dignity.

People receiving a service were supplied with weekly schedules which informed them about the named member of staff who would be attending their call, which kept people informed about who would be caring for them. Staff we spoke with told us they cared for people using the service. They said they were generally allocated onto a run or rota to help provide continuity of care to people. However, staff gave examples about people's calls being removed from their schedule. Staff told us they had contacted the office to ask for the calls to these people to be placed back on their rotas. A member of staff said, "They randomly change rotas- clients seem to disappear some times. It is upsetting for them. I've asked if I can have a couple back next week. We don't seem to get them back." This disrupted the continuity of care provided to people.

During our inspection staff we spoke with told us they treated people as they would wish to be treated. However, some staff had been seen not to be caring in their approach to people. Safeguarding issues were currently being investigated in regard to a member of staff allegedly using a 'sharp' tone with a person. The other safeguarding issues being looked into raised concerns about staff not display a caring attitude towards people because they were seen to use poor infection control and moving and handling techniques which had placed people at risk of harm. Another safeguarding issue currently being investigated was raised because staff did not attend a person's call because they felt the person would have gone out. Staff had not contacted the person or attended to see if the person had gone out and this was not raised with the office staff. This showed us that staff were not always caring in the way they delivered care and support and had not demonstrated sensitivity or empathy towards people who used the service.

Inadequate

Is the service responsive?

Our findings

People we spoke with said staff were responsive to their needs and said they could make complaints if they needed to. One person said, "I would phone the office and they would sort it out." Another said, "I would phone the office- I have no complaints." Two people told us they had raised issues with the service which had been dealt with. One person said, "I would ring the office, I have done once. One of the carers was a little bit brusque and I said I did not want her again and I never have. All the others are wonderful."

Relatives we spoke with said they felt staff were responsive. Relatives confirmed they had seen staff asking for their family member's consent before staff provided assistance to them. A relative told us if their relations needs changed they phoned the service to let them know. They said, "I usually phone, she hasn't had a lot of change- but staff have adapted."

We visited one person in their own home. We looked at their care records. The information in their care plan and risk assessment needed to be updated because their condition had changed in the last week. The care staff in attendance were aware of the person's current needs they said they had informed the office of the changes and a senior member of staff was going to review the person's care and care records.

People had their needs assessed by senior staff and care plans and risk assessments were developed. Staff we spoke with said they felt people's care records were up to date and informed them of people's needs. However, when the registered provider was unable to cover its contractual obligations to some people on 29 May 2015, staff from other providers and the CCG found that the information in people's care records was not up to date. This meant that staff could not respond to people's current needs because the information provided in people's care records was inaccurate. For example, one person should have had their medicine inhalers left by their side in the morning to use if required through the day. Staff had not left them by their side because this was not documented in the person's care records. Another person had a moving and handling plan in place which was dated 2011. The person's health and wellbeing was placed at risk because their moving and handling needs had changed along with their skin integrity. Up to date information was not provided for staff to follow which meant people received inadequate care and support. Staff could not respond to people's needs because they were not fully aware of them. This placed some people at risk of harm.

Staff we spoke with said that they were sometimes given information about people's changing needs with their weekly rota. However, other staff told us they had to read people's care records or past daily entries to try and understand people's current needs. There were few staff who supported the same people, therefore we were concerned that continuity of care had not been provided for people. Staff we spoke with told us they were asked to pick up extra calls to people on a regular basis especially at weekends for people they may have not attended to before. Staff said they had to read people's care records and speak with them to find out their needs. Staff confirmed that people's care records were not always up to date which placed people at risk of not receiving the care they needed.

People we spoke with told us they knew how to make a complaint. They said they would raise issues with the office staff. A person we visited told us that they had received information about how to make a complaint at the start of their service. They said they had raised one issue in the past and things were sorted out to their satisfaction.

Inadequate

Is the service well-led?

Our findings

We asked people what they thought about the service provided. We received the following comments: "The girls are alright, but I don't think office staff are organised." "I've always been quite satisfied."

We gained mixed feedback when we asked people if the registered provider contacted them and asked for their views. Four people we spoke with said they were not asked for their views. Three other people commented: "Once every six months someone asks me." "They phone me from time to time and ask me and I tell them." and "Sometimes they ring and ask how they are doing."

People gave mixed feedback about the registered provider keeping them up to date. Some said they were not kept informed and others said there was occasionally contacted by the registered provider.

Despite some positive comments from people during our inspection we found there were a number of concerns which demonstrated inadequate leadership and management of the service.

The service was required by law to have a registered manager in place. The previous manager was deregistered on 17 December 2013 and although an application had recently been received and processed for a registered manager this post remains vacant. During our inspection we found there was a 'project manager' in day to day charge of the service. They said, "I came for six months and have been here two and a half years." They confirmed they had been in this role since the death of the previous registered manager and told us they never intended to and did not wish to apply to become the registered manager of this service. The registered provider has therefore permitted an unregistered person to manage the service since 17 December 2013. **This is a breach of registered provider's condition of registration under section 33 of the Health and Social Care Act 2008.**

We brought this inspection forward because we had concerns that the management of the service may not be effective to ensure people were provided with a reliable service that met their needs. There were significant shortfalls in the registered provider's ability to cover care calls on 29 May 2015 for that weekend. Other providers of care and the CCG had to provide staff to cover some calls to people using the service or people would have been left without a service. There were shortfalls in staffing which meant people's needs were not safely met and the registered provider did not manage this situation well.

During our inspection we spoke with the project manager we inspected the registered provider's business continuity plans. We found that the registered provider had two business continuity plans in place. One stated that other lead agencies should be contacted for assistance in the event that their service obligation could not be met, and then half an hour after this the CCG should be informed of the issues. [The second business plan was a generic plan which had not been adapted to the business]. When we looked at the evidence it was clear that on 29 May 2015 the CCG was not contacted half an hour after it became apparent covering the calls for people would be problematic. We saw evidence which stated 'It became apparent mid to late morning [approximately 10.30 -11am] that there may be an issue with cover over the weekend of the 30 and 31 May 2015.' The project manager said, "We had the weekend from hell. We always have people on holiday. We realised in hind sight we could have informed commissioning earlier." Failure in following the registered providers own policy and procedure to notify the CCG of the situation in a timely way placed people using the service at risk of harm and demonstrates inadequate management.

The poor management of the service by the registered provider has permitted staffing levels to drop by fifty percent at weekends. On 29 May 2015 and over this weekend the service had insufficient staff to cover its contractual obligation and this was caused by ineffective management because staff had zero hours contracts and were able to tell the registered provider when they were available to work. Management failed to ensure there were enough staff available to allocate work to over weekends and there was no emergency contingency in place that was effective in preventing a catastrophic failure in service to some people. This placed the health, safety and welfare of people at risk. It also placed the staff that were working or who agreed to cover additional care calls under a great deal of pressure. This demonstrated inadequate and poor management of the service.

We inspected the registered providers policies and procedures. We found they were not signed or dated and

Is the service well-led?

there was no review date recorded. The registered provider failed to ensure that up to date policies and procedures were in place for staff to refer to. This demonstrated inadequate quality monitoring of the service.

The registered provider had ineffective systems in place to provide supervision and support to staff. The style of supervision adopted has been ineffective because staff have been observed by staff from other registered providers undertaking poor infection control and moving and handling techniques which placed people's wellbeing at risk of harm.

Although some audits of the service were carried out we found that swift action had not been taken to make sure that people's care records were up to date. Governance arrangements were not in place to ensure people would have their needs met and be protected from receiving poor care. Currently there are 12 safeguarding concerns are being investigated by the local authority's safeguarding team because people received inadequate care and support due to poor management and quality monitoring of the service. The ineffectiveness of the registered provider's system of quality and risk auditing was also demonstrated through the breaches of regulation we found during our inspection that had not been identified by the provider before our visit. Therefore the quality assurance system of assessing and monitoring the service provision of Farringford Care Limited was inadequate.

During our inspection we found that the yearly refresher training for 37 percent of staff had not been undertaken. This placed people at risk of receiving support from staff who did not have up to date skills and knowledge. This means people were placed at risks because the training for staff had not been effectively monitored by the registered provider to ensure it was delivered in a timely way to staff. This demonstrated inadequate management systems were in place at the service.

The registered provider had inadequate system in place to ensure staff received an annual appraisal. The project manager said, "We are not doing very well with appraisals." We were told they were not undertaking these at present. One member of staff we spoke with told us the last appraisal they received was in 2013. Appraisals were not being effectively monitored, planned and managed.

These issues were a breach of Regulation 17 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the registered provider to take can be found at the back of this report.

We were informed by the project manager that the registered provider had recently lost their local authority contract which was ending on 30 November 2015. We were informed that staff may or may not transfer across to the new local authority preferred provider [HICA Grimsby]. Staff we spoke with raised concerns with us that their future and that of the service was unclear. They told us they did not feel informed. The registered provider had ineffective systems in place for staff to raise their views and to ensure they were informed.

We saw during our inspection a response letter to a complainant dated 22 September 2014. The last paragraph of this letter stated: 'I trust the above will address your concerns, if you have any further queries or would like to discuss this response, please do not hesitate to contact either [Name][Registered Manager] or myself the project manager. We saw that a person who had not been registered as the manager of this service at the time this letter was sent out had been described as the registered manager of the service. This was misleading and we were informed this had been a mistake. The registered provider has allowed correspondence to be sent out that was inaccurate it reflected that a registered manager was in place. This misleads the public and reflects inadequate management.

During our inspection we found evidence that an issue about the potential financial abuse of a person receiving a service had not been reported to the Commission. The registered provider is required by law to make the necessary notifications to us in a timely manner. **This is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.**

We found during our inspection that that the registered provider had failed to learn from incidents that had occurred and a sufficient action plan to deal with further emergencies and shortfalls that may occur within the service provision was not in place. We have judged the management of the service was both ineffective and inadequate.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered provider failed to assess, monitor and improve the quality and safety of the service to ensure compliance with the regulated activity. Systems and processes were not established and operated effectively to ensure compliance with the requirements. The service was not assessed and monitored to mitigate risks related to the health, safety and welfare of service users which arose from carrying on the regulated activity. Regulation 17 (1) (2) (a) (b) (c)

The enforcement action we took:
CQC used its enforcement powers to cancel the registered provider's registration to carry out the regulated activity at Farringford Care Limited.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse and improper treatment. Systems and processes must be established and operated effectively to prevent abuse of service users. Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. Care and treatment for service users must not be provided in a way that significantly disregards the needs of the service user for care and treatment. For the purpose of this regulation 'abuse' means theft, misuse or misappropriation of money or property belonging to a service user, or neglect of a service user. Regulation 13 (1) (2) (3) (4) (d) (6) (c) (d)

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
CQC used its enforcement powers to cancel the registered provider's registration to carry out the regulated activity at Farringford Care Limited.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way to people. Care and treatment must be provided in a safe way for service users. The registered provider must assess the risk to health and safety of service users of receiving care and treatment. Do all that is reasonably practicable to mitigate risk. Ensure that person's providing care or treatment to service users have the qualifications, competency, skills and experience to do so safely. Ensure that the equipment used by for providing care or treatment to a service user is safe for such use and is used in a safe way. Ensure proper and safe management of medicines Assess the risk of, and prevent, detect and control the spread of, infections, including those that are health care associated. Where responsibility for the care and treatment of service users is shared with, or transferred to, other person's working with such other persons, service users and other appropriate person's to ensure that timely care planning takes place to ensure the health, safety and welfare of the service user. Regulation 12 (1) (2) (a) (b) (c) (e) (g) (h) (i)

The enforcement action we took:
CQC used its enforcement powers to cancel the registered provider's registration to carry out the regulated activity at Farringford Care Limited.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Personal care

Regulation 18 HSCA (RA) Regulations 2014 Staffing

There were insufficient numbers of suitably qualified, competent, skilled and experienced person's deployed in order to meet the requirements of service users.

Staff did not receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out they were employed to perform.

Regulation 18 (1) (2) (a)

The enforcement action we took:
CQC used its enforcement powers to cancel the registered provider's registration to carry out the regulated activity at Farringford Care Limited.