Complete Professional Care Medway Ltd

Complete Professional Care Medway Ltd

Inspection report

226 Hempstead Road
Hempstead
Gillingham
Kent
ME7 3QG

Tel: 01634386622

Date of inspection visit:
30 March 2017

Date of publication:
23 May 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 30 March 2017 and was announced.

Complete Professional Care Medway Limited is registered as a domiciliary care agency providing personal care to people living in their own homes. The agency was centrally situated in the Hempstead area of Gillingham in Kent and provided a service to people living in the surrounding areas. There were approximately 34 people receiving support to meet their personal care needs on the day we inspected. Some people were living with dementia and some people had physical health needs, mobility difficulties or were frail.

The provider also ran a small care home and an established small day care centre from the same premises.

We last inspected this service on 23 and 26 February 2016 when we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to Regulation 18, Staffing, Regulation 17, Good Governance and Regulation 19, Fit and proper persons employed. Recruitment records were not adequate to keep people safe from receiving care from unsuitable staff. One to one staff supervisions were not held to support and develop staff. The provider did not have a quality monitoring process in place to ensure a safe and good quality service was being provided.

We asked the provider to take action to meet Regulations 17, 18 and 19. At this inspection we found that some improvement had been made to address the breaches from the previous inspection, although other necessary improvements had not been made and further breaches of regulations were found.

The provider did not send an action plan following the publication of their last report as requested and were sent a reminder. We did not receive an action plan but an email, on 17 May 2016, following our reminder, stating they had carried out all the improvements necessary to meet the requirements of the regulations. We asked for further clarification regarding the information set out in the email they sent on 17 May 2016. We sent an email on 02 June 2016 but received no response. We found evidence that the provider had not in fact carried out the actions they said they had undertaken.

There was a registered manager based at the service. 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. The registered manager was absent when we visited, and had been since 27 October 2016. We received a notification to inform us the registered manager was absent, however, this was not sent until 27 March 2017. No arrangements had been made to replace the registered manager to provide the management and leadership of the service in their absence.

During the inspection, as the registered manager nor the provider were available, we had access to the nominated individual of the provider to answer any questions we had. The nominated individual is a person

involved with the service that the provider has informed CQC is the individual they have nominated to provide information on their behalf.

We found that recruitment records were now in order and the provider made sure they had a more robust system in place to check that the new staff they were employing were suitable to work with vulnerable people in their own homes.

Some basic individual risk assessments had been undertaken to help keep people safe from circumstances that might harm them. However, when people were faced with risks that were different to those already identified, or when people's circumstances changed, these were not recorded with measures to control and manage the risk to keep people safe from harm.

When staff administered medicines in people's own homes this was not managed well. Documents to record when staff had administered medicines were poorly kept. Staff were at times administering medicines or applying creams without recording appropriately.

Staff continued to not receive the appropriate support to carry out their role and to progress their own personal development. One to one staff supervision meetings had again not been carried out to discuss their performance and offer support where necessary. Two staff only had an observational assessment carried out in the last year. Observational assessments are a way of the registered manager or provider checking the work practice of their staff working in the community. Annual appraisals had again not taken place since the last inspection to check staff progress in their role over the previous year and to set personal targets for the following year. We found no evidence that a proper induction process was in place to support new staff into their role. Staff did not receive the training updates they required to ensure they continued to have the skills necessary to support people appropriately with their assessed needs.

Although it appeared that most people had the capacity to make decisions in their own home, the basic principles of the Mental Capacity Act 2005 had not been considered during the initial assessment and care planning. We have made a recommendation about this.

Initial assessments were carried out with people before their support commenced. Although care plans were in place, these were often out of date and had not been reviewed and updated when significant changes in people's circumstances had often occurred. Important information and guidance for staff relating to people's care needs had been missed.

The registered manager was absent and no arrangements had been made to replace them with someone who had had the necessary skills and experience to manage and lead the staff team. The notification to inform CQC of the registered manager's absence had not been sent within appropriate timescales.

The provider had not introduced a quality audit and monitoring system following the last inspection to be able to check the quality and safety of the service. The concerns we found had not been picked up by the provider in order to plan the action required to improve the service provision.

Staff knew their responsibilities in keeping people safe from abuse and knew people well so were confident they would notice signs of concern. Staff were aware of where to report safeguarding concerns and said they would always raise anything they were not happy with.

There were enough staff to provide the care and support people needed. Staff were not rushed, were allocated travel time between visits and people always received their full allocated support time.

Few incidents had occurred and those that had related to staff rather than people. We saw that correct recording procedures were used and staff completed the documentation appropriately.

Some people were supported by staff with nutrition and fluids and those people who were told us that this worked well for them. Some people also needed some staff support with their health care, such as making appointments or requesting services. We had positive feedback from people who required this support from staff.

People were highly complimentary about the staff who supported them. All our conversations with people were positive. People had consistent staff who they got to know well and trusted. Staff were always on time and always made sure that people had their full allocated support time.

The provider had sought people's views of the service through an annual questionnaire and collated the information to provide a picture of people's experiences, which were mainly good.

No complaints had been made since our last inspection, however, the provider's nominated individual told us the process they would follow if they did receive a complaint. People had received information about how to make a complaint in the service user guide they were given when they began to use the service.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009 (Part 4). You can see what action we have told the registered provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people's individual safety and welfare were not properly assessed.

Medicines were not recorded and managed well leading to unsafe practice.

Robust recruitment processes were used to keep people safe from unsuitable staff.

There were sufficient staff to ensure people received the care and support they required.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not supported with their personal development through a process of supervision and appraisal. Observational checks were not carried out on staff to check their working practice in the community. Staff did not have the training updates they required.

Capacity assessments were not undertaken with people to check their capacity to make decisions about their care within their home.

People were supported with their nutrition and hydration needs if required and where they needed assistance to maintain their health this was available from staff.

Is the service caring?

Good

The service was caring.

People were highly complimentary about the attitude and caring nature of the staff.

Staff supported mainly the same people every week so they got to know people well. This was valued by the people we spoke

with.

Staff were always on time and always made sure people received their full allocated support time when they visited.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were often out of date so the description of the support people required was not correct. When people's needs changed this was not reflected in their care plan.

People had been able to express their views of the service by completing an annual questionnaire.

People knew how to make a complaint if they wished to do so.

Is the service well-led?

Inadequate

The service was not well led.

A process was not in place to check the quality and safety of the service provided.

There was no clear oversight of the service provided or to ensure care was being delivered appropriately.

The registered manager was absent and no action had been taken to ensure an appropriate replacement was in place to provide management and leadership.

Complete Professional Care Medway Ltd

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 took place on 30 March 2017 and was announced. We gave the provider 36 hours notice because the location provides a domiciliary care service and we wanted to be sure a member of the management team was available to meet with us.

The inspection team consisted of one inspector and one expert by experience. The expert by experience made telephone calls to people who used the service to gain their views. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. This expert by experience was a family carer of a person living with dementia and who uses regulated services.

Prior to the inspection we also looked at previous inspection reports and notifications about important events that had taken place at the service. A notification is information about important events which the home is required to send us by law.

We spoke with ten people who received personal care from the service to gain their views and experience of the service provided. We also spoke to the provider's nominated individual and three care staff. We asked health and social care professionals for their views of the service after the inspection.

We looked at four people's care files including medicine administration records and five staff records as well as staff training records, the staff rota and staff meeting minutes. We spent time looking at the provider's records, including policies and procedures, complaints and incident and accident recording systems and surveys.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection on 23 and 26 February 2016, we found a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe recruitment processes were not used. We asked the provider to take action to meet Regulation 19. The provider sent us confirmation on 17 May 2016 by email that they had addressed the areas required to meet the Regulations.

At this inspection we found that recruitment processes had improved. However, we found additional areas of concern and breaches of regulations.

People told us they felt safe with the care they received from Complete Professional Care Medway Limited. People were particularly happy with the continuity of staff they experienced. The comments we received from people included, "Yes, I have one lady who comes in the week. At weekends I have someone else and this may not always be the same person. If it wasn't for my carer I wouldn't be able to have a shower, I wouldn't be safe having one on my own. I'd have to have a strip wash which is not the same" and "It varies as I have so much care. I do have the same carers in the week. They are very good. They know how to work my bed (a hospital bed) and air mattress". A third person said, "Yes, more or less the same carers come here. They are very kind to me, I don't have any problems".

Safe recruitment practices were now used. New staff went through an interview and selection process. The registered manager and the nominated individual followed the provider's policy which addressed all of the things they needed to consider when recruiting a new employee. This included gaining a full employment record from each applicant and pursuing references before commencement of employment. All new staff had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with vulnerable people. People could be assured they were protected from the risk of receiving care from unsuitable staff.

Some individual risk assessments were in place, however these were not detailed and did not consistently cover all the areas of risk that were evident in the care plan or 'Main tasks and preferences' document. We looked at the care plan of one person who required the support of two staff to care for them in bed, due to their reduced mobility. Risk assessments gave only basic details for staff to follow, such as how many staff were required for the task. A moving and handling risk assessment dated 01 July 2015 was in place. The assessment stated 'review in six months'. However, no review had taken place and the person's mobility needs had deteriorated considerably since then so none of the information was relevant. There was no up to date assessment in place to help to keep the person and staff safe from harm. This meant that when different staff were supporting the person in their home, the personal care tasks that carried a risk may not be carried out appropriately or safely for the individual. A bed guard was in place for one person to keep them safe from falling out of bed. This was briefly mentioned in the care plan but a risk assessment was not in place to identify the potential risks of the bed guard and how to minimise the risks to keep the person safe from injury.

Personal health risks were not assessed separately to identify how people's health conditions may affect them, what staff needed to be aware of and how to respond. We looked at one person's care plan, they had a pressure sore and were at risk of developing further pressure sores. Although district nurses were visiting the person regularly to dress the wound, the care plan stated 'if required, staff change the dressing'. There was no risk assessment or guidance to advise when this intervention by staff would be required, how to change the dressing or what resources may be required, such as gloves. This meant that the person's care may not be consistent which may put the integrity of their skin at further risk. An individual risk assessment was required to identify risks and put control measures in place to ensure staff knew what to do to keep people safe.

One person was prescribed anti-coagulant medicines and although a basic risk assessment stated 'Carers are to be aware of potential risks that [person] could occur due to taking anti-coagulant medication'. No further detail was given to advise and guide staff what the specific risks were and what to do if the staff did encounter the person exhibiting excessive bleeding or bruising.

The failure to assess and mitigate individual risks was a breach of Regulation 12 (1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Most people either took care of their own medicines or a family member or friend assisted with this. However, some people did need the assistance of staff to help them to take their prescribed medicines.

Medicines were not always managed safely for those people who did require assistance. A 'medication profile' was in place to list the medicine's people were prescribed and how often they should take them. However, we looked at the records of one person who required support with their medicines and their medication profile was dated 23 September 2014 with no review of the documentation since then. There was no evidence that this medication profile was up to date and the person's prescribed medicines were unchanged since 2014. The medication profile of another person who staff also administered medicines for was blank. Medicines administration records (MAR) were not recorded in a consistent and safe manner by staff. The MAR's were sloppily recorded; dates were not completed correctly as the year was not added the majority of times, for example, dates were recorded as 19/2, 26/2, 28/2; some staff recorded, 'as per medication sheet' others recorded, 'as per blister pack' and other staff recorded, 'as per dosette box; staff did not stay within the lines on the recording sheet so the recording was very messy and hard to read. There were lined areas on the MAR for staff to record in, however staff were not staying within the lines – one MAR sheet had nine lines available to record in and there were 29 lines recorded by staff between the nine lines on one sheet and 21 lines recorded on another sheet; a column was available to tick if the person had 'self administered' or if staff had 'assisted with' medicines, on two MAR sheets we looked at staff had ticked both boxes.

There was no indication what medicines were within the blister packs, so there were no records of what medicines staff were actually administering. No guidance was available for staff as to what medicines people were prescribed and what the side effects to watch out for were. No auditing had taken place by the provider or the registered manager to monitor the quality and safety of the medicines administration by staff. We saw poorly recorded MAR's back to July 2016 and none of these concerns had been picked up prior to our inspection.

One person's care plan made a reference to 'assistance with medicines required'. Staff had recorded in the person's daily record sheet that they had 'Assisted with meds'. However, we found no MAR for staff to sign when they had assisted with medicines, which medicines they had administered and at what times. We asked the provider's nominated individual about this and they did not know if the person received support

with medicines administration or not.

Staff recorded in some people's daily records 'applied creams' and 'creamed legs', however, none of these were recorded on a MAR. No guidance was in place how to apply creams, where to apply or how often the creams should be applied. No guidance was available to advise staff if the creams they were applying had any side effects for the person, or for themselves, if for example, gloves were not used.

The failure to safely manage medicines administration was a breach of Regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Staff understood their responsibilities in keeping people safe and knew how to report any suspicions of abuse and who to. Staff told us that they knew people well, as they mainly supported the same people every week, this meant they would notice quickly if people were showing signs that would raise their concerns. They said they would be able to find out what was wrong as they had built an element of trust with people.

Accidents and incidents were reported appropriately when an incident happened. A recording of the incident, including what happened and the action taken was recorded in an accident book. The only incidents recorded had been accidents that had happened to staff. No incidents were recorded involving people who used the service. The provider's nominated individual confirmed there had been no incidents to report for people who used the service.

An emergency plan was in place to make sure staff and the emergency services had the information necessary to deal with an emergency situation that might arise. However, no contact details were included for staff to know who to contact in such a situation. We spoke to the provider's nominated individual about this who said this was an oversight and they would make sure they added contact details as soon as possible.

There were sufficient numbers of staff available to meet the needs of the people the service was supporting in the community. Through our discussions with people and staff members, we found there were enough staff with the right experience to meet the needs of the people who used the service. The records we looked at such as the rotas confirmed this. The rotas also confirmed that enough time was allowed between visits for staff to get from one person's home to another so that people got their support when they expected it. People told us they always got their full support time, staff did not leave earlier than planned. The comments received included, "They [staff] are not usually late. They stay for the time they are supposed to" and "Not too bad. I expect them between 09.00 and 09.30 in the morning and they are usually here on time. Once there was a road accident nearby and the carer rang to say she was held up. Then I got a call from the office to tell me as well". Staff told us they always supported the same people which meant there was consistency to ensure people received safe care.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection on 23 and 26 February 2016, we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. One to one staff supervisions were not held on a regular basis and observational assessments of staff in the community had not been carried out. We asked the provider to take action to meet Regulation 18. The provider sent us confirmation on 17 May 2016 by email that they had addressed the areas required to meet the Regulations.

At this inspection we found that the provider had not improved their practice to meet the regulations, as no one to one supervision meetings had been carried out and only very few staff had an observational assessment since the last inspection.

People told us they thought the staff knew what they were doing when they were supporting them in their home. One person said, "Yes they know how to help me turn in bed as I can't get up at the moment. It's important to do it properly. They know about my air mattress and hospital bed". Another person told us, "A relative of mine is a carer as well. She can see that they are working properly and checks on the book to see what's been written".

The provider and the registered manager had continued to not give staff the opportunity to have one to one supervisions to support their personal development since the last inspection. This meant that staff had not had formal one to one supervision of their progress and to offer personal support since the end of October 2014. We saw evidence that one member of staff had two observational assessments in the last 12 months and another member of staff had one observational assessment. Observational assessments are used to support staff working in the community by observing their practice and giving feedback, advice and guidance to ensure good quality and safe practice is used consistently when supporting people in their own homes. The provider's supervision policy stated staff should have one to one supervision every three months. The provider and the registered manager had also continued to not give staff the opportunity to have an annual appraisal in order to reflect and receive feedback on their work practice the previous year and set targets for personal development in the following year. Staff had not been given the opportunities for personal development or to gain constructive feedback about their work. Staff confirmed they had not received supervision. Staff also told us they had received little support, particularly since the registered manager had been absent from their role. The provider would not have been able to ensure staff had the ability to carry out their role in a safe and proficient manner.

We found no evidence that new staff had received an induction at the beginning of their employment. We looked at one member of staff's file who started employment in November 2016. We found no evidence that the member of staff had any training since starting their role. There was no evidence of shadowing staff who knew what Complete Professional Care expected of their staff or an introduction to the people they supported.

We looked at staff training records. We found that staff had not had sufficient refresher training to ensure their knowledge and skills were kept up to date. All training except moving and handling training was

completed by staff reading information about the subject and completing a question and answer sheet. The moving and handling training was completed face to face in a practical setting with the provider's nominated individual. Out of the five training files we looked at, all the training that had an expiry date had not been refreshed and was therefore out of date. For example, first aid training for every staff member's training record we looked at had an expiry date of either July 2014 or June 2016. Moving and handling hoist awareness training for every staff member's record we looked at had expired in 2014 or 2016. Most training staff had undertaken had taken place in 2014 or 2015, only one training course, MCA awareness, had been seen to take place more recently, in 2016.

The failure to provide sufficient staff support, development and appraisal was a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff supported people to make decisions about their care when this was appropriate, for example, how people liked to have their support and at what times.

We did not see any evidence of mental capacity assessments having been undertaken with people. Although most people supported appeared to have the capacity to make the decisions within their own home, there was no reference to the MCA and if this had been explored with people and their family members.

We recommend the provider and registered manager gains information and advice from a reputable source in order to develop a system of ensuring they are guided by the principles of the MCA when undertaking initial assessments and when reviewing people's care and support.

Although many people did not need staff support with their meals as they managed this themselves, or family members or friends helped them, some people had assistance with meal preparation and cooking within their home. Some people needed to have their whole meal cooked for them by staff. Some people had microwave meals that staff prepared at meal times. Others had meals delivered to their home that were ready prepared and just needed to be put into the oven. This was clearly recorded in the 'main tasks and preferences' document. People who did receive support from staff with their meals were happy with the arrangement. One person said, "I suffered from a loss of appetite which is now returning, so have a light lunch. They prepare the dinner for later on for me and make me a hot drink. I can manage to get water for myself, but they do remind to drink plenty". Of their regular carer, a person said "She knows how much I like my cup of tea, she always makes me one". Staff supported those who required their assistance with nutrition and fluid intake.

Some people did not need the assistance of staff to make contact with health care professionals such as GP's or district nurses as they managed this themselves or a family member or friend helped. Some people did not have the support of others and asked staff to help them to make appointments or to ring the GP surgery for advice. People told us how the staff helped them with their health concerns and if they had specific advice from health care professionals, how the staff took note of this. For example, one person told us that they needed to move from side to side as they were at risk of developing further pressure sores. They told us that the staff always followed the plan that the district nurses had left in the person's home. People who needed support with their health and well-being were supported by staff to maintain their health when necessary.

Good

Is the service caring?

Our findings

People told us that they felt the staff knew them well and knew what was important to them. Some of the comments made when we spoke to people included, "They [staff] are considerate, I have two regular carers in the week and different ones at the weekend, but I know them all" and "They're more like family now, I get quality care" and a third said, "I get to know the carers and they get to know me and my husband". Further comments included, "We get on well, we talk while they are working. One said last week 'I'm always learning new things from you!'" and "They are very helpful. I can ask them to do things extra for me".

The staff we spoke with said the staff team were very caring and they felt they did a very good job supporting people. One member of staff said, "The staff there are very nice and all try their best".

People's care plans showed what their likes and dislike were. For example, how people liked to have their cup of tea and where they liked things to be positioned at the end of their support time before staff left, or the programmes they liked to watch on television. One person liked to watch a programme about antiques as they had an interest in antiques and had been a collector over the years. People told us that staff knew them well and knew what they liked and did not like. One person told us, "Yes, I'm very particular about having switches turned off. I check and they do switch them off", and another person said, "They know about my poor appetite and don't over face me with food".

The emphasis of support was to maintain people's independence. Privacy and dignity were considered throughout the care planning process. Care plans guided staff to leave people in private whenever possible and to support people to maintain their independence throughout the delivery of care. Comments in the care plan such as, 'Allow time for [person] to do as much as they can for themselves' and 'Likes to do as much as possible for themselves, housework, washing etc' evidenced this. We asked people if staff respected them and their home and one person told us, "Yes of course she does, I've no problems" Another person said, "Yes, I'm very happy".

The daily notes made by staff showed that staff visited at the times people had stated were their preferred times. People told us that staff were usually on time and that they always stayed for their full amount of support time. If staff were going to be late, people told us they always contacted them to let them know. All the people we spoke with were very happy with their support and the consistency of the staff supporting them was a key element to their contentment.

People signed a service agency agreement setting out what they could expect from the service including the responsibilities of Complete Professional Care (Medway) Limited and the responsibilities of the person. For example, how much notice people were required to give if they wished to cancel a care visit.

The provider had a service user guide which they made sure people had a copy of when their support began. The guide detailed all the information people and their family members would need while they were receiving support from the service, including contact details and who they could go to if they had concerns about their service such as the local authority or the Care Quality Commission (CQC).

Requires Improvement

Is the service responsive?

Our findings

Some people could not remember having been involved in an assessment of their needs or in their care plan. However, other people could clearly remember and everyone we spoke with knew that the folder kept in their home contained information on their needs and that the staff wrote in the folder. One person said, "I can't remember an assessment. I was in hospital so think it must have been started there. I've got a folder here with my details in". Another person told us, "I've had carers for years, but with this company I sorted out what I wanted myself. I had a review of mine, I've read it and it checks out".

We saw evidence that an initial assessment was undertaken with people before support commenced to check the staff had the experience and skills to support people with their care needs. The registered manager had a checklist in place itemising all the information they needed to tell the person about the services they provided. This made sure that the person was given all the information necessary whichever staff member undertook the assessment.

One person's initial assessment said staff were required to assist the person in and out of the bath as they could not do this by themselves. The care plan or the 'main tasks and preferences' document did not go on to state that staff should assist with bathing or guidance how to do this or on what days. Staff had not recorded in the daily recording sheets that they had assisted the person to have a bath. It was therefore unclear if this assessed support need was being undertaken.

One person had a 'Person centred care plan' dated 05 November 2014. A review sheet stated care plans had been reviewed every six months and the sheet was signed to say no changes were needed to the care plan in January 2016 and January 2017. In July 2016 the answer to 'any changes from the last review' was 'yes'. However, no changes had been made to the care plan even though that person's needs had clearly changed significantly in that time due to the fact they suffered from a progressive illness. Their illness had reduced their ability to move around their home since November 2014 and they were now cared for in bed. They had previously been able to get around their home and undertake some domestic tasks including some housework and preparing meals but they were now physically unable to do any of these tasks. This was not apparent from the person's care plan as no changes had been made. A 'Main tasks and preferences' document was more up to date and showed the basic care and support required by the person in their present circumstances. This document was more reflective of the care being given by staff. However, these documents were not dated so it could lead to confusion, particularly for new staff, whether the care described was up to date and current. Staff told us that people's care plans and risk assessments were not being updated and reviewed and that they had reported when this was the case, but there was no one available to review the paperwork in the absence of the registered manager.

One person required staff to administer barrier creams for the prevention of pressure sores, mentioned in the main tasks sheet, to be applied at the am visit. However, the barrier cream was not recorded as being applied by staff in any documentation. One person had a catheter in place, this was recorded in their initial assessment which stated that the catheter should be replaced by the district nurse every eight to ten weeks. The main tasks sheet stated 'staff to empty the catheter bag every night'. No care plan or risk assessment

was in place to give further advice and guidance to staff regarding good catheter care and what to do or who to contact if they had concerns, or if they noticed that the catheter had not been changed by the district nurse as recommended.

Some documents within some people's care plan files were blank, such as medication profiles, details of lasting power of attorney and to check people's lifelines. This could be misleading, for example one person's environmental assessment stated they had a lifeline in place, yet the document for staff to routinely check the lifeline was in working order had not been completed, with no explanation why.

The daily notes showed that some people were being given food supplement drinks by staff when they visited. This was not recorded in the care plan as a task that staff were expected to assist with. There was no record of which health care professional had advised the supplement or how often they should take them. Food supplement drinks are not a substitute for nutritious food and should be taken with advice from a health care professional when people are frail to be sure the correct supplement is taken. Therefore, staff should only be assisting with supplement drinks if the advice and guidance from a health care professional is clear and documented. Although staff had recorded in the daily notes when they had given a food supplement drink, this was not a regular recording so it would not be possible to be sure people were having their supplement drink at the times advised by a health care professional. For example, in one person's daily notes staff had recorded that they had given a food supplement drink on the following dates in a seven day period; 12, 13, 18 and 19 February 2017, no recordings had been made on the other three days. The provider could not be assured that staff were always recording when they had assisted with the food supplement drink as there was no proper recording mechanism for staff to sign, such as a MAR. Therefore it was unclear whether people were reliant on staff to assist with their food supplement drinks or whether they were managing themselves or had assistance from a family member or friend on the other days. The unreliable documentation could lead to people not receiving the support they required to stay safe and well.

Only one out of the four care plan files we looked at was detailed with the required up to date and dated information.

The failure to ensure people's care needs were recorded accurately and kept up to date by being aware of people's changing needs was a breach of Regulation 9(1)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

The provider asked people for their views of the service once a year. A questionnaire was sent to all the people who used the service, the most recent was sent in February 2017. Only four questionnaires had been returned when we visited. One of the office staff told us this was usual and they expected more to be returned over time. Staff would be picking up those that had not yet been returned by post if people wanted them to. Comments included, 'I have four different carers come out to me and they are very good, I would not want to change them for anyone else'. The previous survey had been completed in March 2016 when 19 questionnaires had been returned. The majority of the feedback received from people at that time had been very good. One comment seen was, 'Very satisfied with all the staff and care workers. They are all very good at their jobs. My father has got a good team of care workers'.

People were given information during their assessment about how to make a complaint if they needed to. Further information about how to make a complaint was detailed in the service user guide that was given to people to keep. No complaints had been received in the last 12 months and all the people we spoke with told us they had no reason to make a complaint as they were happy with the support they received from staff. One person said, "I've never had to make a complaint, I've got no problem with them". Another person commented, "Yes, I had a problem once but it got sorted out, I've no problems now'".

Inadequate

Is the service well-led?

Our findings

At our previous inspection on 23 and 26 February 2016, we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have a system of carrying out quality assurance audits to ensure a safe and good quality service was being provided. We asked the provider to take action to meet Regulation 17. The provider sent us confirmation on 17 May 2016 by email that they had addressed the areas required to meet the regulations.

At this inspection we found that no improvements had been made, as the provider continued to not have effective systems in place to monitor the quality and safety of the service provided.

The people we spoke with said they had not considered if the service was well managed from the office as they were happy with their care. The comments we received included, "I think it's ok, I've not had any problems", and "I've had no problems with their management", and "I ring occasionally if I need to change the time of a visit, if I have a doctor's appointment for example. There's never been any problem".

The provider had not introduced any auditing systems in order to monitor the service provided even though they had told us on 17 May 2016 by email that they were meeting the regulations. We found there were no systems in place to monitor the quality and safety of the services provided within the domiciliary care agency. We found a number of concerns during our inspection as described within this report. We discovered that some of the areas of concern found at our last inspection continued, as the provider had not made all of the improvements they said they had. None of these areas of concern had been identified by the registered manager or the provider, as effective systems were not in place to check and monitor the services provided. This meant that the provider was not ensuring the safety of people or making sure they were providing a good quality service as they did not have systems in place to alert them to shortfalls in care and safety.

We were shown a 'Monitoring and quality assurance' report, completed for the period 1 January 2016 to 31 December 2016 by a member of staff working in the office. This stated that 35 monitoring visits had been made to people's homes in the period. When we looked at the visits we saw that only 14 people had received monitoring visits in this period. We were told that it was the amount of visits that had been counted, not the numbers of people visited. Therefore 14 people had received 35 visits between them to check if they were happy with the service and if any changes were required to their support. This meant that 20 people had not been visited at all to monitor the service they received. The 'Monitoring and quality assurance' report stated that 60 monitoring telephone calls had been made in the same period, however these were not documented so there was no evidence of the calls having been made. People did not tell us they received telephone calls from the office although they did say they had completed questionnaires.

The provider's nominated individual told us the daily records were collected from people's homes to bring in to the office every six months. This meant the registered manager or the provider could not check to make sure staff were recording the support they carried out appropriately. If a concern with recording was picked up it could be too late to address the concern after a period of up to six months.

Staff had not received one to one supervision, observations of their work in the community, or annual appraisals and staff meetings were not held regularly as the last meeting had taken place on 7 August 2016. This meant that staff were not given the support and encouragement to carry out their role supporting people in their own homes in the community. The provider was not aware that this was the case as monitoring systems to check staff support and development were not in place.

The registered manager had received no supervision since the last inspection although we were told by the provider by email on 17 May 2016 that, 'Management supervision is now in place and a log is completed of this'. The registered manager had received no training since the last inspection although they were new to the role at the last inspection. We were told by email on 17 May 2016 that the registered manager had signed up to complete a training course for MCA and the Deprivation of Liberty Safeguards, (DoLS) and was awaiting dates to attend. However, this had not happened and they had not received this training. The registered manager had not attended any safeguarding vulnerable adults training to equip them with the skills to be able to advise and lead the staff team to keep people safe. The last training they had received on this subject was by way of an in house adult protection questionnaire in February 2015. At this time they were a senior care worker, without the responsibilities expected of a registered manager. The registered manager was not equipped with the necessary support, skills and training to be able to advise and guide staff appropriately to ensure people received a good quality service.

Staff told us they thought the service was not managed well and they did not get the support they required. Staff were aware the registered manager was absent. However, they said that arrangements had not been put in place to replace them, which meant staff were not receiving the support they required. One member of staff said, "The staff in the office are very nice and try to be helpful but they have their own jobs to do and cannot give the help that is needed".

The failure to have systems in place to audit and monitor the quality and safety of the service provided and the failure to have suitable and robust recording systems was a breach of Regulation 17 (1)(2)(a)(b)(c)(f)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the provider sent a notification to CQC that the registered manager was absent from their role for 28 consecutive days or more, this was not received fully completed until 27 March 2017. The notification stated the registered manager had been absent since 26 October 2016. A registered person is expected to notify CQC 28 days or more before the proposed absence, except in the case of emergency. In an emergency situation, the registered person must notify CQC within five working days of it's occurrence. The registered manager had been absent since 27 October 2016 and appropriate arrangements had not been made to ensure the management of the regulated activity in their absence. A suitable person had not been appointed to ensure the responsibility for the management of the carrying on of the regulated activity was held by a person with the experience and qualifications necessary to do this.

This is a breach of Regulation 14 of the Care Quality Commission (Registration) Regulations 2009 (Part 4). Notice of absence.

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 14 Registration Regulations 2009 Notifications – notices of absence The provider failed to notify the commission of the absence of the registered manager within a reasonable timescale. No arrangements had been made to find a replacement to manage the regulated activity in the registered manager's absence.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider and registered manager failed to ensure people's care needs were recorded accurately and kept up to date by being aware of people's changing needs.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager failed to assess and mitigate individual risks to people to keep them safe from harm. The provider and registered manager failed to ensure the safe management of medicines administration

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 17 HSCA RA Regulations 2014 Good governance The provider and registered manager failed to have systems in place to audit and monitor the quality and safety of the service provided, had no clear oversight of the service and failed to have suitable and robust recording systems.

The enforcement action we took:

CQC served a warning notice on the provider

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider and registered manager failed to provide staff with sufficient support, development and appraisal to ensure they had the skills and experience necessary to deliver the care and support people required.

The enforcement action we took:

CQC served a warning notice on the provider.