Care Quality Commission

Angels DCS Limited

Angels Domiciliary Care Services

Inspection report

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Date of inspection visit:
09 January 2019
10 January 2019
11 January 2019
18 January 2019

Date of publication:
20 February 2019

Ratings

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

Summary of findings

Overall summary

We carried out an announced inspection at Angels Domiciliary Service Limited on 11, 12, 13 and 18 January 2019.

Angels Domiciliary Service Limited is a small domiciliary care agency in Chorley. It is a family run business running from the family home which covers the Chorley and South Ribble area. The service is registered for dementia, learning disability and autism, older people, physical disability, sensory impairment and younger adults. The service provides personal care to people living within their own homes. At the time of the inspection fourteen people were using the service.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found six breaches of the Health and Social Care Act 2008 (Regulated activities) Regulations 2008 and once breach of the Care Quality Commission (Registration) Regulations 2009) We found shortfalls in the management of medicines, the staff recruitment process, staffing levels and safeguarding people from abuse. We also identified further shortfalls in dealing with complaints, the governance arrangements and as well as failure to provide statutory notifications.

We are considering what action we will take in relation to these breaches. Full information about the CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded

At the last inspection carried out in May 2017, the service was rated as good, however we found that at this inspection there had been significant deterioration in the quality and safety of the service being provided. At this inspection, the rating of the service had deteriorated to inadequate.

Safeguarding adult's procedures were in place and staff were aware when to raise concerns. However safeguarding incidents were not always being documented or reported to the local authority safeguarding team. A recent safeguarding investigation regarding an individual not receiving commissioned support through the agency was substantiated.

Complaints were not being managed, recorded and responded to appropriately. People using the service, relatives and staff did not always feel listened to. One person's care package was cancelled when they raised a concern about the registered manager.

We found shortfalls in the management of medicines. There had been several incidents around medication and not all staff had received medication training.

There was a lack of training for staff within the service. Neither management or the staff team had received any training in moving and handling, fire safety, health and safety or food hygiene. Supervisions were not being undertaken as frequently as they should have been.

Staffing levels were low and there had been a high turnover of staffing within the service. Rotas were constantly changing and people were not always receiving the hours they have been commissioned for.

We found shortfalls in the recruitment of new staff. Recruitment was unsafe. Of the three files we looked at, only one reference was received out of six. There was also a lack of understanding of the risks posed by the employing inappropriate people to work in the service.

There was a lack of confidentiality within the service. Service users, relatives and staff were aware the registered manager crossed professional boundaries.

Complaints were not being managed, recorded and responded to appropriately. People using the service, relatives and staff did not always feel listened to. One person's care package was cancelled when they raised a concern about the registered manager.

We saw people's care files contained environmental risk assessments, falls risk assessments and moving and handling risk assessments. However individual risk was not well managed and concerns around people's safety were not always identified. Accidents and incidents were not always being documented.

There were significant shortfalls in the way the service was led. The provider did not have effective systems to assess, monitor and manage the service. They did not have processes to learn lessons and drive improvement.

There was a lack of statutory notifications being sent to CQC and a lack of monitoring and auditing of the service.

The provider was working within the requirements of the Mental Capacity Act (2005) and we saw evidence of capacity assessments in place.

People had access to healthcare professionals. Assessments and care plans in place included people's personal histories and social interests, which enabled staff to build relationships.

People were complimentary about the staff who looked after them. They told us the staff were caring and they felt confident in them. They liked the continuity of staffing that they received from the small team and felt in particular that a senior member of the care team was efficient.

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If insufficient improvement is made within this timeframe so that there is still a rating of 'inadequate' for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying

the terms of their registration within six months if they do not improve.

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

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 unsafe

Safeguarding's were not being raised with the local authority

Risks were not being managed appropriately

People requiring 2-1 support were not always receiving this. Commissioned hours were not always been received.

Staffing levels were low

Recruitment was not safe

There were concerns around medication and not all staff had been trained

Is the service effective?

Requires Improvement

The service was not effective.

Capacity assessments were taking place.

People told us they liked the consistency of having regular staff.

Staff had not received appropriate training and supervision to undertake their role effectively.

Is the service caring?

Requires Improvement

The service was not caring.

Not all people felt listened to.

Some people felt disrespected by the management.

People were complimentary about the staff team and a senior member of the team.

People had detailed life histories which helped to build meaningful relationships.

Is the service responsive?

Requires Improvement

The service was not responsive.

Assessments and care plans were in place, although some had incorrect details.

There was evidence of reviews taking place.

People did not always receive appropriate guidance on how to make a complaint.

People who raised concerns felt victimised. Complaints were not handled appropriately.

Is the service well-led?

Inadequate

The service was not well led.

The culture of the service was not open.

The registered manager had not followed recommendations from a safeguarding investigation.

The registered manager had stated in her statement of purpose that she was a nurse when this was not the case.

Audits were not robust to pick up issues found within the service.

There was a lack of notifications to CQC which meant we could not assess the risk within the service.

Care Quality Commission

Angels Domiciliary Care Services

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

We carried out a comprehensive inspection of Angels Domiciliary Care Services on 10, 11 12 and 18 January 2019. The inspection was undertaken by one adult social care inspector. The provider was given 48 hours' notice because the location provides a domiciliary care service to vulnerable adults. We needed to be sure people who used the service, staff and the registered manager would be available to speak with us. We used the 48-hour notice period to speak by telephone with service users and relatives of people who used the service. This was to gather their views and opinions of the support people and their family members received.

Prior to our inspection of the service, we were provided with a copy of a completed provider information return (PIR); this is a document that asked the provider to give us some key information about the service, what the service does well and any improvements they are planning to make. This provided us with information and numerical data about the operation of the service.

In preparation for the inspection, we reviewed the information we held about the service such as the PIR, notifications, complaints and safeguarding information. This included statutory notifications sent to us by the service about incidents that affected the health, safety and welfare of people supported by the service. A notification is information about important events, which the service is required to send us by law.

We contacted the Local Authority safeguarding team, the local commissioning teams and the local Healthwatch organisation to ask them about their opinion of the service. This helped us to gain a balanced overview of what people experienced accessing the service.

We contacted three people who used the service and five relatives via telephone interviews. We also visited and spoke with two people within their own homes. We spoke with the registered manager, the administrative director of the service, the deputy manager and four support workers to ascertain their views on the service.

During the inspection we looked at care records of three people who were supported at the service. We looked at three staff personnel files and reviewed a range of records relating to how the service was managed. This included recruitment records, staff training records, medication administration records, quality assurance systems and policies and procedures.

Inadequate

Is the service safe?

Our findings

At the last inspection we made recommendations around keeping people safe. We recommended that the agency reviewed its safeguarding reporting procedure to ensure that all actions are recorded accurately and that when potential issues are discovered, whenever possible, this is discussed directly with the person in receipt of care and care support to ensure their voice is heard. We saw that a safeguarding adult's policy was in place and staff had signed to say that they had read and understood it. Most of the staff we spoke with had a good understanding of safeguarding and said they would feel comfortable raising concerns

There had been a safeguarding investigation in January 2018 and a recommendation from this was that all staff should receive safeguarding adults training. From reviewing the records we could see that all staff received safeguarding training in April 2018. However, we noted that two staff that had started since this date had not received this training. This was raised on inspection and training was promptly booked.

There were increasing concerns around one individual's safety being supported at home and staff had raised this with the registered manager. This vulnerable person was at an increased risk when leaving their home due to disorientation, which increased their vulnerability when outdoors. There had been occasions when they had become lost and these incidents were not reported to the local authority safeguarding team. We saw no evidence in the accident and incidents file of any incident reports completed in respect of these.

We were made aware that one individual had not been safe living at their home for the past three months and staff felt that they were locking them in their house. There was conflicting information around whether this person could use a key and get out of the house, in the event of a fire. These concerns had not investigated further or been raised as a safeguarding matter with the relevant authority.

This issue of not recognising when to raise a safeguarding had been a common theme at the previous two inspections. This was discussed with the registered manager who expressed that she felt "people would think she was not coping if she raised safeguarding's" and that in her own way," she was trying to protect families."

A safeguarding was raised during inspection by the registered manager due to increasing concerns and a discussion took place around the need to escalate such concerns and to share information of concern with the relevant authorities. The same individual had been without heating and hot water periodically for a period of at least ten days due to a dysfunctional boiler. We saw evidence of records stating, "{service user} can't live like this. She is so cold," and another stating, "concerned about the house been very cold, no heating in the house, have contacted {family member} to tell him." The registered manager had raised this with the family, but did not escalate the concerns further.

We felt the service was not embedding safeguarding procedures in their practice and needed to be more responsive to concerns raised. Although most of the staff we spoke with said they would feel comfortable raising concerns, we did not feel confident therefore that the registered manager was ensuring people were being fully protected from abuse, neglect and discrimination.

This was a breach of Regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Management of risk was not always effective. Specific risks relating to individuals were not identified. For example, we were made aware that one individual had a significant history of mental health difficulties. We did not see any reference to this history or concerns highlighted in the risk assessment, nor was it identified in the care plan. Where people had behaviours that may challenge the service, there were no personalised risk assessments to support staff in managing the behaviour effectively. This meant that staff were often managing people with complex needs, with little support and guidance and risks were not being managed.

There was a failure to assess the risks to the health and safety of service users. This was a breach of Regulation 12(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence of falls risk assessments in place, medication risk assessments, moving and handling risk assessments and generic risk assessments in people's files. Although moving and handling assessments were in place, staff had not received moving and handling training. Two people that used the service required support with transfers, one of which required the use of a transfer turntable and belt. Discussion took place around how staff were trained to use the equipment. The registered manager told us that she had shown them how to use the equipment, despite not having had updated her moving and handling training since 2013.

The generic risk assessment identified environmental hazards and identified the location of emergency utility cut off points. Staff members had not received any training in health and safety and the registered managers had not updated her own practice in this area since 2010, prior to setting up the agency. Two staff had received fire safety training in 2015 and 2016 respectively and the registered manager had not updated her training since 2013. Following on from the inspection all staff had been booked on mandatory training, which included fire safety. We discussed the Lancashire Fire and Rescue Service free training course on offer and the registered manager said that she had been unaware this available but did routinely refer individuals for a fire safety check.

We noted that personal evacuation plans (PEEPS) were not being devised. A PEEP is a personal evacuation plan for individuals who may not be able to reach an ultimate place of safety unaided or within a satisfactory period of time in the event of an emergency. One individual was being locked in their own home and due to impaired cognitive ability could no longer use a key to escape in the event of a fire. No considerations in the event of a fire had been documented.

People commissioned to receive a package of care requiring two carers were not always receiving this. Concerns were raised prior to inspection that staff were being asked to support an individual on their own, despite the assessment clearly stating two carers and the service being commissioned to do so. The registered manager stated that in her opinion the individual did not need that level of support. The registered manager was told that she was to deliver the amount of care that people had been assessed by the local authority to receive and any changes to that package of care would need to be authorised by them. We have since been advised that the registered manager contacted the local authority following inspection. We made it clear to the registered manager that if she could not cover all the packages of care that she had taken on, she would need to act responsibly and contact the local authority with a view to people receiving alternative support.

At the time of inspection, a safeguarding concern around a person not receiving the right amount of support was raised. This was later substantiated by the local authority safeguarding team as there were no records

to evidence what support had been provided. One relative we spoke with, also raised concerns about an inconsistency between the hours that their relative was commissioned for and the number of hours they were receiving. According to both the provider and the relative, the service user had been commissioned for 16 hours of support a week. On reviewing the rotas, we saw that during the week commencing 17th December, 11.5 hours support was planned and during the week commencing 24th December 9.5 hours had been included on the rota. This indicates that people were not always receiving their commissioned hours of support.

Rotas were not planned effectively. There were not enough staff to cover calls and staff were down to be in several places at the same time. For example, on the 9th January, one staff member was on the roster for a 9-10am shift, a 9.15-9.45 shift and a 8.30-9.30am shift. One staff member described the rotas as 'chaotic' and one relative said the visits were 'haphazard, with times varying from day to day. Staff found it hard to have a work/life balance when the rota was constantly changing and some worked long hours with little time off." People we spoke with felt the staff were stretched and were worried that the staff struggled to take time off for holidays. We observed staff calling into the office regularly during our inspection, discussing rota changes with the registered manager. The service had a high turnover of staff and plans for a two-weekly rolling rota as discussed at the last inspection had not yet materialised.

The provider failed to ensure that sufficient numbers of suitably qualified, competent skilled and experienced persons were deployed. This was a breach of Regulation 18 (1) Staffing of the Health and Social Care Act (Regulated Activities) Regulations 2014.

All registered services are required to carry out a range of pre-employment checks before new staff start work. This is to ensure that staff are suitable to work with vulnerable adults. During the visit we looked at three staff member's files to assess how the provider managed staff recruitment. We saw that the provider had performed a check on the Disclosure and Barring Service(DBS) update service to ensure that one staff member had a valid DBS check in place. The DBS carry out a criminal record check on individuals who intend to work with children and vulnerable adults, to help employers to make safer recruitment decisions. We saw that out of three staff recruitment files we looked at, only one reference out of a possible six had been received. We also found gaps in employment histories, with one person only detailing a 3 year employment history. This meant that the provider was following their own recruitment policy and there was potential for vulnerable people to be supported by unsuitable staff. The rota's also showed that a person was working within the service, however there were issues of concern related to this persons' suitability to work with vulnerable people.

The provider had failed to operate an effective and robust recruitment and selection procedure. This was a breach of Regulation 19 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The systems in place to ensure that people received their medicines safely was not robust. A safeguarding alert was raised during the inspection around medication concerns. One individual was accessing their medication, in addition to staff also administering it. We had concerns around the appropriate storage of medication and the risks of overdose to this individual. Further discussion took place with the inspector about the immediate need for an interim measure to be put in place to minimise the risks of this reoccurring. We were assured measures would be put in place.

We looked at medication training and saw that some staff had completed medication training in May and June 2018. However, we noted that the medication training had only taken place as a consequence of a serious medication error had occurred at the end of March 2018. This lack of appropriate training for staff had been previously highlighted in January 2018 when an organisational safeguarding alert by social

services took place. The protection plan agreed with the provider at that time, stated that "all staff to be put on/update relevant training."

We looked at the records relating to the serious medication error that occurred by the registered manager where a person received too much medication which resulted in their admission to hospital. We did not feel that lessons were learned as a result of this error to prevent similar issues arising in the future. For example, staff that had started work since the incident, only received informal training from the registered manager and did not receive accredited training for several months.

From looking at the MARS sheet we saw that there were some gaps and we saw messages in a communication book where it seemed to be frequent practice for staff to be asked to sign for medication at a later date, or for other people. This was unsafe practice as the person signing the chart was not the person who administered the medication.

One relative told us, "The records do not tally. Records show that pills have been given and signed out and then I see pills on the coffee table." One service user told us that the registered manager had recorded that she had prompted her to take her medication when she had not.

We became aware of another incident around medication, where miscommunication between the agency, pharmacy and family had meant that one individual had gone without important medication.

There was a failure to operate effective systems to ensure the safe management of medicines. This was a breach of Regulation 12 (1) (g) Safe Care and Treatment of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at the accidents and incidents file. We saw that although some incidents had been recorded, ones relating to serious incidents occurring within the service were not being recorded. For example, there was no incident forms relating to the person that had been at risk in the community, medication miscommunication or the incidences where a person had no heating or hot water in their property.

Most staff had received infection control training and we observed staff wearing appropriate personal protective equipment (PPE). We saw that an infection control policy and procedure was in place. The new staff that had not received infection control training at induction, had been booked onto a mandatory course which included this. People we spoke with confirmed that staff wore gloves and aprons and our discussions with staff indicated that they had a good understanding of infection control.

Requires Improvement

Is the service effective?

Our findings

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA) The procedure for people living in their own homes is called the Court of Protection authorisation. We saw that the service had an MCA policy in place and people's capacity had been assessed. From the training matrix we could see that the registered manager had received training in the principles of MCA in 2018 but care staff had not received training. However, we observed staff asking consent when supporting individuals and they had an understanding of how mental capacity works in practice. Plans were in place to undertake mandatory training which will include a module around the Mental Capacity Act.

We looked at how people were supported to maintain their health. We found all people were registered with a GP and had access to other healthcare professionals, such as district nursing and mental health nurses. We saw information in people's care plans about specific medical conditions, such as angina. This helped staff to have more insight into how people's healthcare needs impacted on their daily life.

People we spoke with told us the staff were good and they felt confident in them. They liked the consistency of staffing that they received from the small team and felt that the deputy manager was efficient. We looked at how the provider trained and supported their staff. Staff told us there had been difficulties with training, where they had been told some online training was going ahead, then didn't materialise. One staff we spoke with told us they had received training in safeguarding adults, infection control and general data protection regulation training.

We looked at the staff files and the training matrix to determine what training staff had actually received. We found staff training to be very limited. We looked at moving and handling training and saw that the registered manager had not completed training since 2013 and two members of staff had training in 2016. The remaining 5 members of staff had not received any training on moving and handling at all. The service was supporting people who required support with transfers and some people who were assessed as needing 2-1 staffing for moving and handling.

The provider booked staff onto training during inspection and showed us confirmation of this. They told us that they had experienced difficulties sourcing training due to some of the training firms that they had used had gone out of business. We looked at health and safety awareness training. According to the training matrix the registered managers health and safety training has not been updated since 2010 and only one staff had received training in 2015. No training had been undertaken in Equality and Diversity. The administrative director was providing direct support to one individual, a family member but had not received any formal training to do this.

There was a failure to provide appropriate training for the staff team. This was a breach of Regulation 18 (1)(2)(a) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at what arrangements were in place for the induction of new staff. Staff spend time in the office

having an initial orientation of the service around its aims and values and familiarisation with the organisation's policies and procedures. Staff shadowed other staff for a period of least two weeks and learned about the needs of the service users. One staff member told us how she spent several hours going through paperwork relating to medication with the registered manager. Staff were always introduced to people before they began supporting them and new staff we spoke with told us they felt supported through induction. One new staff explained she had completed the Care Certificate. The Care Certificate aims to equip people who are "new to care" with the knowledge and skills which they need to provide safe, compassionate care.

The service had a staff supervision policy in place, which stated that all staff should have one formal supervision every three months and two direct observation supervisions. We looked at records of staff supervisions and saw that formal supervisions were not taking place consistently. We saw that some appraisals had taken place. One newer member of staff had received two supervisions over a three-month period, whereas another staff member had only received one supervision since January 2018. The service was not following their own policy and procedures in terms of supervision.

A recommendation from the safeguarding investigation in January 2018 stated that supervisions should take place monthly. We raised this with the registered manager who told us that she was always available for staff and with being a small agency they did not feel they needed to formally document supervisions. She advised that the deputy manager had more management experience in terms of supervising staff and she had recently taken over the staff supervisions.

We noted nutritional assessments were taking place and people had meal planners in place. People told us that staff supported them to prepare meals. Staff had not received food hygiene training from the service, although two staff had received training in the past when they worked in hospitality roles.

We discussed best practice and the registered manager said she referred to National Institute for Health and Care Excellence (NICE) guidance and kept updated through CQC updates. We noted that some guidance was outdated, in particular the generic care plan review document. We discussed the importance of keeping up to date with practice and regulations.

The service explained that they had good working relationships with other providers and shared one person's care with another care provider.

Requires Improvement

Is the service caring?

Our findings

We received mixed views about the caring nature of the service. People did not always feel listened to. They described how the registered manager crossed professional boundaries by talking about her own personal issues. Another person told us how she could be overbearing. There was a clear distinction between the care staff and the registered managers approach. One person told us "The girls have a gentle manner and manage my relative beautifully. I am totally confident in the care from the deputy and the girls."

People felt they were supported to be independent and most people spoken with said that staff respected their dignity and privacy. Not all people felt they were respected. One relative we spoke with felt there was no privacy for her when the registered manager was around. She told us, she felt that the registered manager interfered. She did not feel respected in her own home.

One person felt victimised for speaking up. They felt the service was not caring towards them. They felt by raising an issue, they had jeopardised their care, as they were given notice, by the registered manager.

There was a lack of confidentiality within the service. Although the service had a confidentiality policy in place, this was not being followed. Service users knew details about other people being supported in the service and people's personal situations were not always kept private. For example, one person told us, the registered manager had told her, "she had to deal with someone who was at risk and needed a Dols." We raised the seriousness of this with the registered manager and explained the need to keep information private.

Most of the staff were kind and compassionate. One person told us the staff were "superb" and most people were very happy with their care. We saw compliments about the caring nature of the service. One person had written, "[Registered manager] will go the extra mile and makes every effort to provide the best care possible and is conscientious in her work."

Staff we observed treated people with dignity, respect, kindness and some people told us they went above and beyond their duties. One person explained how they, 'Do the laundry for me, which is really helpful. Other agencies won't do that." One relative said that Angels had done a fantastic job and because they had gone in to support their relative, it allowed them to remain a further 12 months in their own home.

The registered manager was passionate about the care she provided. She told us, "I'm often told I do more than most care companies and go the extra mile. I wear my heart on my shoulder." This was reflected in the comments people told us about. Another person said,"The [registered manager] has a heart of gold." Another person said; "she throws 110% effort at it."

We saw warmth and humour in the interactions with people. People spoke highly of one senior staff member, one person said, "[Staff member] is very, very, good." Another person said "[Staff member] is extremely capable." Staff felt this staff member led well. One relative described her as being "absolutely brilliant. She is so cheerful and has such a kind, caring nature, my relative looks forward to seeing her."

The provider told us that they kept the same staff working with the same people to provide consistency of care for people. People confirmed that they usually had regular staff, one person said, "It's great, I have the same staff member to give me a shower, rather than lots of different staff."

People had detailed life histories in their care plans which helped staff members to build meaningful relationships. Staff we spoke with demonstrated that they understood people's individual personalities, needs and preferences and spoke warmly and positively about their work and the people they supported. People benefited from having a full hour of care and one person told us, "Nothing was too much trouble."

People were well informed about the services on offer and were provided with appropriate information in the form of a service user handbook. The service had an equality and diversity policy and procedure in place and staff we spoke with were able to demonstrate that the care and support they provide should be specific to each individual's needs, wishes and preferences.

Although no one was using advocacy services at the time of inspection, the registered manager explained how she had promoted advocacy and signposted people to relevant services.

Requires Improvement

Is the service responsive?

Our findings

We looked at how the provider was managing complaints. We had been made aware that one relative had barred the registered manager from the house, due to overstepping professional boundaries. We did not see any evidence of this complaint being recorded or investigated.

People told us they did not always find it easy to raise issues. Some people we spoke with mentioned that the registered manager could at times have an "aggressive manner" and was reactionary.

One service user told us that the registered manager was forgetful when providing care and it was difficult to bring it up, with her being the manager. We were aware of a complaint prior to inspection that had been handled very poorly. The registered manager had been providing support to an individual and recorded that medication had been prompted, when it hadn't. The service user raised this error and did not receive an appropriate response. There was a failure to provide an apology in line with the services own policies and procedure and the person was given notice of cancellation. The service user told us they felt victimised and bullied.

There was a failure to appropriately manage complaints. This was a breach of Regulation 16 (1) Receiving and acting on complaints of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Assessments and care plans were in place. We saw evidence of activities of daily living, background information and social interests were also included. People's routines were described and there was section detailing "important things about me." Staff we spoke with felt they had sufficient information to know what was required of them on each visit. We saw that initial assessments took place with the registered manager prior to people starting the service.

One person did point out that their health details were incorrect and they referred to another individuals health needs. This was raised an issue with the registered manager. We saw there were arrangements in place to review and evaluate people's care plans. However, we saw that in one person's file the date care had commenced was recorded as 11/11/2015 with a review date of 2016, when the service had only started in 2018.

We saw evidence of a generic care plan review document that detailed needs such as capacity, mobility, skin integrity, psychological support and medication. The care plan also detailed communication needs. We saw evidence of one where the care plan referred to one individual's deterioration in communication and how staff should take more time when giving instructions. We observed staff putting this into practice on one observed visit and reassuring the individual. People and families felt involved in their care and although there was some evidence of person centred care, we found that vital information was missing in some people's care records. For example one person's mental health was not addressed in the care plan and risks and concerns that we had identified on inspection had not been identified and addressed. Risks around one person using the stairs had not been documented, to ensure risks were minimised.

We checked if the provider was following the Accessible Information Standard (AIS). The standard was introduced on 31st July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand and any communication support that they need. We looked at how the provider shared information with people to support their rights and help them with decisions and choices. Although the registered manager was unaware of the AIS, discussion took place about how they could produce information in a different format. The registered manager was able to give an example of where she had provided large print versions of care plans for an individual in the past.

Staff completed daily records which provided information about what support had been given. We saw these were signed and dated and included the times of the visits.

The service had supported people who were at end of life. We saw a compliment from one family stating, "[staff member] looked after my mum whilst she was ill with cancer, she was exceptional and her staff. Nothing was too much trouble." Despite providing end of life care, we saw no evidence that staff had received training in this area.

Inadequate

Is the service well-led?

Our findings

People told us the registered manager overstepped professional boundaries and that she told people about her worries regarding the operation of the service. Some people also told us of their concerns that they had been party to confidential information about others who were receiving care from the service. This approach had led to a lack of confidence in the management of the service.

The provider was struggling to recruit and retain staff and at the time of the inspection. The registered manager was trying to carry out two roles and she was not fulfilling her duty as the registered manager. We were aware that recommendations made in January 2018, as a result of a safeguarding investigation had not been implemented.

Appropriate audits were not taking place. Client file audits were taking place in a tick box style where the audit was initialled only. There was no scope to write what had been found of any actions arising from these findings. Medication audits were comprehensive up to one year ago. However, since then these had just become a tick box exercise and were very limited. We found no audits taking place on complaints, incidents and accidents. Audits that were in place were not robust and did not pick up on the issues found during inspection.

There were significant shortfalls in the way the service was led. The provider did not have effective systems to assess, monitor and manage the service. They did not have processes to learn lessons from incidents and accidents and the outcome of safeguarding investigations as a way of improving the service. The provider did not have up to date guidance to follow which ensured they met certain standards.

There was a failure to audit and monitor the service to improve the quality and safety of the service. This was a breach of Regulation 17 (1) (2) Good Governance of the Health and Social Care Act (Regulated Activities) Regulations 2014.

All registered person have a statutory duty to notify Care Quality Commission without delay of specific events and incidents which occur in the service. It was evident from our inspection that we had not been notified of specific incidents in line with current regulations. This meant that we were not able to consider and monitor the level of risk at the service. The registered manager told us she was not aware that she had to report incidents to Care Quality Commission.

There was failure to notify the Commission of notifiable incidents. This was a breach of Regulation 18 Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009.

The culture of the service was not always open and transparent. The registered manager did not always inform outside agencies such as the local authority when risks to people using the service were identified. We found incidences that should have been reported to the local authority but this had not been undertaken. We were not confident in the registered managers ability to identify, respond and act on risks appropriately.

The registered manager told us that they, "Often pick up packages of care that other care companies will not take." This indicated that the agency were potentially supporting people with complex needs. It was clear that arrangements had not been made to ensure that staff had received all the training necessary to care for people who had more complex care requirements.

During the inspection we obtained a copy of the Statement of Purpose for the service. This clearly stated that "the service was privately owned by a former nurse of 34 years with a wide range of nursing experience both in the private and public sector." The statements contained within the Statement of Purpose and the client handbook were misleading as the registered manager was not a qualified nurse. Potentially this could mean that prospective service users would be expecting a level of skill and expertise from the registered manager which she was neither qualified nor professionally registered to provide. We asked the registered manager to amend the Statement of Purpose and submit it to us as a statutory notification. We also asked for the client's handbook's to be amended, so that people using the service had the correct information.

The registered manager told us she felt that she was "too soft with staff." She explained that had not managed staff previously and was worried that staff might leave. She told us that one staff would not attend training and did not know how to address this. The registered manager relied heavily on a senior member of the care team for support.

Some relatives we spoke with felt that the registered manager needed help and support with management skills and guidance. She told us she was currently undertaking the level 5 diploma in leadership for health and social care. At times, we observed that her approach was not always professional. The office felt disorganised and rotas were being done less than a week in advance which meant that staff had very short notice of when and where they would be working. We observed constant changes to the rota and overheard that one person was upset because they had received a visit when it had been previously cancelled.

There was no system in place for call monitoring to ensure that calls were not missed. One person told us that the registered manager had failed to turn up for a lunchtime visit and when she contacted the office to ask what was happening, she was told she had made an error due to not changing her clocks, despite this being 3 days after the clocks going back. The person was upset that it had been recorded in their file as "due to time constraints she didn't attend," which was not the case.

Another person told us, "I rang the office because I didn't think anyone was coming the other day. It makes you worry when they are late, but [a senior staff member] is very good and will ring to let me know." We raised this issue with the provider who told us that as they were a small company and did not have the funds to provide the monitoring. They explained that all staff ring the duty manager at the end of their shifts, but there was currently no monitoring of individual visits taking place.

We saw records of duty manager handover notes but were informed that these had only recently been implemented in July 2018. These were notes that the manager made of any issues, concerns that had been raised by staff during their shift. We were told that service user satisfaction surveys had been sent to people but no replies had been received.

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 12 HSCA RA Regulations 2014 Safe care and treatment There was a failure to assess the risks to the health and safety of service users. There was a failure to operate effective systems to ensure the safe management of medicines.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There was a failure to ensure people were being fully protected from abuse, neglect and discrimination.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was a failure to appropriately manage complaints.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to audit and monitor the service to improve the quality and safety of the service.

Regulated activity	Regulation

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed There was a failure to operate an effective and robust recruitment and selection procedure.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was a failure to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed. There was a failure to provide appropriate training for the staff team.