U5 Limited

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Inspection report

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Date of inspection visit:
31 March 2016
01 April 2016
29 April 2016

Date of publication:
25 July 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

U5 is provides personal care for people aged 18 years or over who need care or support at home. At the time of this inspection 187 people were in receipt of support from the service. The majority of people who used the service had their care funded by their local authority. People could also pay for their own care.

Prior to our visit, we had received information of concern about the quality and safety of the service provided. This information prompted our visit. We gave the provider of the service short notice before our visit to ensure they would be available to participate in the inspection. 24 hours after we notified the provider of our intention to visit on the 31 March 2016, they contacted The Commission and informed us that in their own judgement the service they were delivered was inadequate and they intended to close the service at the end of their contract with the Local Authority. They said this was due to consistent staff shortages which had impacted on quality of the service provided. Our inspection of still went ahead and we carried out the inspection on the 31 March 2016, 1 and 29 April 2016.

There was a registered manager in post who participated in the inspection visit. 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'.

A senior manager had been employed by the provider to provide managerial support to the registered manager. Both the senior manager and the registered manager reported to three Directors of the service (the provider) in relation to how the service was managed. These Directors were present during the inspection and were involved in the day to day running of the service also. We liaised with the provider and senior manager for the majority of our inspection.

During this inspection, we found breaches of Regulations 9, 11,12, 13, 14, 16, 17, 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

We looked at the care files belonging to 17 people who used the service. We found they did not adequately cover people's needs and risks. They failed to provide clear information or guidance to staff in the provision of safe and appropriate care. This placed the person at risk of harm. Care plans were not personalised to people's individual needs and preferences and staff lacked sufficient guidance on how to provide people with person centred care.

We found that where people had mental health conditions which may have impacted on their ability to consent to decisions about their care, their capacity had not been assessed in accordance with the Mental Capacity Act 2005. Staff had no guidance on how to support people with mental health needs and appropriate action had not been taken where people's mental health impacted on the ability of staff to

deliver their care.

We saw from people's daily logs that they did not always received the care they needed at the required times or for the length of time that they had agreed. People regularly experienced visits that were too early, too late or missed altogether. Some people's visits were not appropriately spaced, so that sometimes breakfast and lunch and lunch and tea times visits were only an hour or so apart. We did not find evidence that people's needs were consistently followed up when visits were late or missed or evidence that the provider checked that people received the support they needed. People we spoke with confirmed this.

During the irregularity of visits, some people did not receive their medication at regular times. People's medication administration charts showed gaps in the administration of medication that were unexplained and did not demonstrate that people always received the medication they needed or in a safe way.

People did not receive support with meal preparation to promote their nutritional health at consistent or appropriate times. Others went significant periods of time in between visits which compromised their personal care.

There was no evidence that the provider had checked on people's welfare or reviewed their care to ensure that the support people received continued to be suitable for their needs. Where people's support needs had changed, people's care plans had not been updated. This placed people at risk of inappropriate or unsafe care.

There were no adequate staffing arrangements in place to enable the provider to be confident that people's needs would be met. The provider was fully aware of the staff shortages but had taken no effective action to review people's care to ensure that the number of staff employed could safely deliver the care required.

No action had been taken to monitor how many visits were too early, too late or missed altogether. When we looked at the visit records, we found staff were sometimes booked on more than one visit at any one time, meaning they were impossible to achieve. Despite this information being available, the provider had not utilised this information to plan staffing arrangements, to arrange agency cover or to mitigate any risks. This meant the provider failed to safeguard people from the risk of harm.

There were gaps in the training of some staff members and some training had not been updated since 2011 and 2012 which meant it could have been out of date. Staff lacked appropriate supervision in their job role and their skills and abilities had not been regularly evaluated by the provider to ensure they were competent to deliver care to people to an appropriate standard.

Staff were subject to pre-employment and criminal record checks prior to employment to ensure they were suitable to work with vulnerable people. People we spoke with told us that the staff who delivered the care were kind and caring and did their best.

We saw that the provider had a satisfactory complaint policy in place. We looked at the two complaint records the provider had on file. We found that they had been properly responded to but we found that other people's concerns about their care had not been resolved or addressed.

For example, we saw that people's views about the quality of the service had been sought by the provider by telephone survey. Over half of the people surveyed raised concerns about their care but there no evidence that any action had been taken to address their concerns and on the days we visited, people's feedback remained the same.

Two people we spoke with and a relative told us that they had complained to the provider many times about the quality of the service and the care they received. One person "You may as well talk to the table". Another said "The Company is terrible".

There were no effective audits in place to check the quality and safety of the service. We found that the provider and the registered manager lacked the appropriate management skills and accountability for the quality and safety of the service. The provider had failed to ensure the registered manager and staff followed policies and procedures, failed to follow their own quality monitoring system, and had failed to take any action to protect people from risk.

During our visit on the 31 March and the 1 April 2016, we raised serious concerns with the provider about the safety of the service and asked them to refer the care of some of the people whose care file we looked at to the local authority safeguarding team to protect them from further risk. We also asked them to take appropriate action to mitigate any further risks to people's health, safety and welfare. Despite this on our return to the service on the 29 April 2016, we found no effective action had been taken to address our concerns and ensure people were safe.

The overall rating for this provider is 'Inadequate'. This means that it was placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures are inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This leads to cancelling their registration or to varying the terms of their registration within six months if they do not improve. Such services are kept under review and if needed can be escalated to urgent enforcement action.

Where necessary, another inspection is conducted within a further six months, and if there is not enough improvement we would move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

However, after our visit on the 29 April 2016 and in conjunction with the Local Authority, the provider closed the service and people's care was transferred over to an alternative home care provider. Due to the seriousness of our concerns, the closure of the service was brought forward by the provider in conjunction with the Local Authority and The Commission and occurred within five weeks of our initial visit. This meant that people were protected from any further potential harm.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People said they felt safe with the staff who visited them but told us visits were often missed, late or irregular. This meant people were sometimes left without the support they needed when they needed it.

Risks in relation to people's care had not been properly assessed or managed. This meant people were not protected from harm.

Support for people who required assistance with medication was inconsistent. It was unclear if people received their medication in accordance with prescribed instructions.

Staff were recruited safely but the number of staff on duty was inadequate. This placed people at significant risk. Risks in relation to the shortage of staff had not been addressed by the provider.

Is the service effective?

Inadequate

The service was not effective.

The Mental Capacity Act 2005 had not been followed to ensure people's capacity was assessed where they had mental health issues that may have impacted on their ability to consent.

Staff lacked any guidance on the risks and support people needed in respect of their mental health.

Some staff had not received appropriate training, supervision or appraisal. This meant the provider could not be confident staff were competent to provide safe care.

Due to the irregularity of people's visits around mealtimes, people's dietary needs and hydration needs were not always met as planned or at appropriate times for them.

Is the service caring?

Inadequate

The service was not always caring.

Some of the people we spoke with told us that they had raised concerns with the provider about the quality of their care but no improvements had been made. This did not demonstrate that the provider dealt with people's concerns in a caring and meaningful way.

People told us that they did not receive a call to check on their welfare when a visit was missed or late or advance notice that a call may be late. This did not demonstrate that the provider cared about people's welfare.

A telephone survey completed with people who used the service raised concerns about the irregularity of their visits but there was no evidence the provider had addressed any of their concerns.

People we spoke with said the staff who provided care in people's own home were kind. People said the carers were "Lovely" and "Great, really kind and are overworked so that's why they are late".

Is the service responsive?

Inadequate

The service was not responsive

Care plans and risk assessments were not person centred and failed to identify people's needs and wishes.

Personalised care was not delivered as people were not always supported at the times they wanted, with the care they needed or for the required length of time.

People's daily logs indicated that sometimes people's welfare was compromised by the lack of regular visit times.

There was a complaints procedure in place. Not all of the complaints received had been documented or appropriately responded to.

Is the service well-led?

Inadequate

The management and leadership of the service was inadequate.

There were no effective quality assurance systems in place to monitor the quality of the service or to mitigate any risk to people's health and welfare.

There were no effective staff management systems in place to

ensure staff were capable and competent in their job roles.

There were no systems in place or any appropriate action taken in relation to staff shortages or with regards to the deployment of staff to ensure people needs were met safely.

The provider had not always notified the Local Authority or The Care Quality Commission of notifiable incidents such as safeguarding incidents, serious injuries or staff shortages so people could be protected from further potential harm.

Due to the seriousness of the concerns identified during the inspection. The provider in conjunction with the Local Authority and The Care Quality Commission closed the service.

U5 Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 31 March, 1st April and the 29 April 2016. The first day of the inspection was unannounced. The inspection was carried out by three adult social care inspectors.

Prior to our visit we had received information of concern from the relatives of people who used the service and other professionals involved in the protection of vulnerable adults. We looked at any information we already had about the service and information we had received since our last inspection.

We visited and spoke to five people in their own homes during our visit to talk to them about the care they received. We planned to talk to ten people but unfortunately due to people's needs and care, access was not always possible and some people were not in when we called.

At this inspection we also spoke with the three directors of the service who were 'the provider', the senior manager, the registered manager, the care co-ordinator and six care staff. We looked at a variety of records including 17 care records, people's daily logs, five staff records, staff training records, a range of policies and procedures, a sample of medication administration records and other documentation in relation to the management of the service.

Inadequate

Is the service safe?

Our findings

People we spoke with had mixed feedback about the service. They all felt safe with the staff who visited them but the majority of the people we spoke with told us that visits were often missed or late.

We looked at 17 care files belonging to people who used the service and a sample of their daily logs. Daily log information records the actual date, time in and out of visits and the support provided. We found that people's daily logs were not adequately maintained or completed after each visit. At times, due to the quality of the handwriting they were also impossible to read. This meant it was not clear whether people actually received the care they needed.

The daily logs we looked at confirmed what people had told us in respect of late or missed visits. Records showed that people's visits were regularly late, too early or missed altogether. A significant proportion of people's visits did not take place at the planned time and staff did not regularly stay the amount of time agreed. This meant that people's needs were not met as planned. We also found that the majority of late and missed calls were not followed up consistently by the provider to ensure people were safe. This placed people at risk of harm.

We saw that the provider had a contract with the Local Authority to provide care to people in their own homes. This contract stated that where a staff member was unable to complete a visit as planned, a replacement must be sent within the hour. When looked at the people's daily logs, we found little evidence that a replacement visit was made. The majority of people had to wait until their next planned visit for any support to be provided. This left people vulnerable and at risk of harm.

We asked the provider how calls were monitored to ensure people received the care that they needed. They told us there was an electronic monitoring system in place called I- CARE that enabled staff to check in and out of visits via their own mobile phone. When we enquired further about how this system was used to monitor the visits planned and undertaken we were told that the electronic data was not looked at in this way. This meant that the provider did not use the electronic data to track late, missed or irregular visits to mitigate any risks to people's health and welfare and ensure they received the support they needed.

These examples were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to provide care in a safe way that prevented avoidable harm or risk of harm.

We asked the provider for staff rotas. They told us that they did not have any. When we asked how staff members knew which visits to undertake each day, we were told that that workers received a list of visits each day via the I-CARE system to their mobile phone. We asked the provider how they knew which staff member was allocated to which visit each day. They told us that they only knew what visit a staff member was allocated to when they logged into the system via their mobile phone on arrival at people's homes. This meant that the provider and registered manager did not know which visits staff were supposed to attend on any given day in order to be confident people's needs were met.

We asked the provider what information they were able to access from the I-CARE system to show that visits were appropriately planned. We were provided with electronic copies from the I-CARE system of each staff member's 'bookings list' for the month of April 2016.

When we looked at this information it was immediately obvious that staff were unable to achieve some of the visits as they had been double or often triple booked or the visits planned were 'back to back' leaving no time for travel in between visits. It was clear from the information provided that the number of visits planned could not be achieved in accordance with what had been commissioned by the Local Authority in support of people's needs as the number of staff employed was inadequate.

For example, one staff member was booked on five separate 30 minutes tea time visits and another was booked on four separate visits at the same time. All the staff bookings lists we looked at showed that at various times throughout their shift, staff members were allocated to more than one person's visit at the same time. This meant it was impossible for staff to provide people with the support they needed at the required time or for the length of time needed. It also led to a consistent pattern of late and missed visits.

The provider told us that they had experienced significant staff shortages over the last few months that had impacted on the ability to deliver the service and the care people required. It was clear from our discussions with the provider that they knew people were placed at risk.

These examples were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to ensure that sufficient number of suitably qualified, competent and experienced staff were deployed to meet people's needs.

The provider had a policy in place for identifying and reporting potential safeguarding incidents. Staff we spoke with demonstrated an understanding of potential types of abuse and the action to take should abuse be suspected. Not all of the safeguarding issues we identified during our visit or safeguarding incidents identified by the provider prior to our visit had been reported to The Commission in accordance with legal responsibilities.

We found little evidence that any appropriate internal action had been taken to address and mitigate any risks to people's health and welfare through a lack of sufficient staff. For example, through a review of people's care packages to ensure that the number of staff employed could safely meet people needs or by transferring those people's care back to the Local Authority where their needs could be safely met. In addition, neither the provider nor, the registered manager had notified the Care Quality Commission of the risks posed to people's health and wellbeing by staff shortages.

Where people had experienced missed and late calls, these incidences had not been consistently reported to the Local Authority as a serious incident in accordance with the Local Authority contract and local safeguarding procedures. The provider has also failed to notify The Commission in accordance with statutory notification procedures. This meant that procedures in place to protect vulnerable people were not followed by the provider to safeguard people from harm.

These examples were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider failed to protect people from improper treatment, potential neglect and harm.

When we looked at people's care files, we found that the majority of people's needs and risks were not properly assessed, managed or documented. Care records gave staff limited or no guidance on how to

meet people's needs and minimise any risks. Care records kept at people's homes were also incomplete and not regularly reviewed.

For example, one person was identified by the Local Authority as living with a specific health condition. This health condition predisposed the person to speech and swallowing difficulties, cognitive issues, poor mobility and a lack of co-ordinated movements. Despite this, no assessment of the person's condition or any associated risks had been considered in relation to the delivery of the service by the provider. There was no information in the person's care plan about their condition, the signs or symptoms for staff to spot should the person's health decline or guidance on how to provide safe and appropriate care.

We saw from both the local authority information and U5's moving and handling risk assessment that the person had pressure sores on their bottom and on both legs. Pressure sores are wounds that develop when constant pressure or friction on one area of the body damages the skin. Despite this, the person's care plan made no reference to the person's pressure sores or the care the person required to prevent further skin deterioration.

One person's referral information from the local authority indicated that the person was prescribed a specific medication. The medication was described as being vital for the person's health and wellbeing. The local authority referral information clearly specified that U5 staff were to "monitor the use of this medication on every visit" in order to prevent a "life threatening situation". When we looked at the person's care plan it made no reference to this medication or the responsibility of U5 staff to monitor its usage. There was no risk assessment or management plan in place to advise staff how to ensure the amount of medication consumed was sufficient to meet the person's needs or what to do in an emergency situation. This meant staff had no information about this medication, its importance to the person's health and well-being or the actions required by them to keep the person safe.

We asked the senior manager about this. They were unaware that the monitoring of this medication was the responsibility of U5 staff. We checked the person's daily logs for April 2016 and saw that there was no evidence staff monitored the use of this medication as required. This demonstrated that the person did not receive the care they required in order to keep them safe.

These examples were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there was no suitable system in place to ensure that risks in relation to people's care were adequately managed.

We checked a sample of people's medication administration records (MAR). We found unexplained gaps in people's medicine administration records which had not been investigated by the provider. This meant that we could not verify if the medicines had been administered. We were unable to determine whether this was a recording issue or whether the dose had been missed because regular medication checks of people's medication had not been completed by the provider or registered manager.

People's daily logs showed that their medications were not prompted or administered at consistent times due to the irregularity of people's visit times. For example, one person's medication was prompted at 7:42 am on one day but prompted at 10:23 the following day. There was also no information in people's care files with regards to the time their medication should be taken. In addition, the daily logs for some people did not show that their medication prompts had been consistently given by staff. This meant it was unclear as to whether the person had been prompted by staff to take their medication or not.

For example, one person's daily logs showed that visits were frequently missed. The senior manager told us

that the person would regularly refuse staff entry. This meant that the provider could not be sure that the person had taken their required medication. There was no evidence that the person's GP or social worker had been contacted to discuss this.

Medication risk assessments and people's ability to administer their own medication were completed but they had not been regularly reviewed to ensure any medication risks were appropriately managed. We also found that information provided to staff in relation people's medication was inconsistent. For example, one person's care plan stated staff were to just prompt the person to take their medication but there was a MAR in the person's home signed by staff to indicate staff had full responsibility for administering the person's medication on a daily basis. In some care files, the person was indicated as self-medicating yet their daily logs clearly indicated that staff were involved in the administration process. Some people were identified as requiring a medication prompt but the person's daily log indicated the person self-medicated. This placed people at risk of taking more medication than they needed or not receiving the medication.

These examples were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there was no suitable system in place to ensure that people received the medication they needed when they needed it.

During our visit we asked the provider to make safeguarding referrals to the Local Authority with regards to the people whose care we had looked at.

We looked at the staff personnel files of five staff members who worked for the service and found that adequate pre-employment checks had been carried out by the provider. These checks included identify checks, two reference checks from previous employers to confirm their satisfactory conduct and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups, by disclosing information about any previous convictions a person may have. This meant the provider had checked to ensure staff members were employed were safe to work with vulnerable people.

Inadequate

Is the service effective?

Our findings

Some of the people whose care files we looked at required support with meal preparation to ensure that they received adequate nutrition and hydration. When we looked at people's daily logs however we found that people did not always receive the support they required when they needed it due to missed or late visits.

For example, we saw that another person's breakfast visit was late 39 times during February, March and April 2016 occurring after 11am and sometimes as late as 13:45pm. For 22 of these visits, there was no evidence any breakfast had been made when the staff member finally arrived.

One person's breakfast visits were late 24 times in March and April 2016 with the latest breakfast visit recorded at 13:30pm on their daily log and another person's breakfast calls were significantly late fourteen times in March 2016 which meant that for 48% of visits in March 2016, this person did not receive the nutritional support they required when they needed it.

People's daily logs showed that staff did not always ensure people had had sufficient amounts to eat and drink. For example, one person daily logs showed that for 43% of the visits completed during the 18 February to the 29 March 2016, there was either no reference to the person being supported to eat or the person's daily log showed that they had refused food. This meant it was impossible to tell if this person had received sufficient nutrition and hydration in accordance with their needs. There was also no evidence that any action had been taken to ensure this person's dietary needs were met or that concerns with the person's social worker and GP had been raised.

A relative we spoke with told us that the only hot meal the person received each day was prepared by U5 staff. They said that call times varied significantly and were often late. This relative told us that "One of the carers left (the person) to finish off the cooking themselves, they (the person) nearly set the place on fire".

On looking at people's care plans, we found that people's dietary needs and risks had not been assessed which meant that staff had no clear guidance on how to meet people's nutrition and hydration needs. For example, three people whose care files we looked at lived with diabetes. Despite this no diabetic risk assessment had been undertaken and there was no guidance for staff to follow when preparing the person's meals. There was no information on potential diabetic complications for example if the person experienced a hyperglycaemic or hypoglycaemic attack [high and low blood glucose levels) or the action staff should take if such an attack occurred.

Another person's care file indicated that they had previously been referred to the community dietician due to weight loss. Despite this, no assessment of the person's risk of malnutrition had been undertaken or management plan put into place to ensure this person's dietary intake was adequately promoted by staff. We also saw that one person was referred to the Local Authority Safeguarding Team by a Speech and Language Therapist due to the failure by U5 staff to follow clinical guidance in respect of the person's diet which placed the person at risk.

These examples were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there was no suitable system in place to ensure people's nutritional needs and hydration were met.

We spoke with six staff members, the majority of whom said they had received adequate training and felt supported in for their job role. The staff records we reviewed however did not demonstrate this was the case.

We reviewed the provider's training schedule which identified the training needs of each member of staff and the date they had last completed the training. Mandatory training was offered in a range of subjects including; health and safety, infection control, fire safety, first aid, food hygiene, medication, mental capacity, moving and handling and safeguarding. The training schedule showed that the majority of staff had received some training in 2014 or 2015. There were however gaps in the training of some team members and some training had not been updated since 2011 and 2012. This meant it may have been out of date.

For example, there were no dates recorded for one member of staff who commenced employment in July 2015 as having completed training in safeguarding, fire safety, first aid, infection control, health and safety, food hygiene, dementia or mental capacity. This meant potentially they had worked for eight months without adequate training at the time of our visit.

Training dates for two staff in first aid and infection control were recorded as 2011 and for three staff, training in relation to fire safety, first aid, health and safety and food hygiene were all recorded as 2012. Three staff members responsible for preparing food had no training dates recorded for food hygiene and some staff had been enrolled on NVQ Level 2 and 3 courses but it was unclear whether these had actually been completed.

We asked the provider about the gaps in the training of some staff members. They told us that the training schedule was out of date and not a true reflection of the training staff had completed. This meant it was difficult to tell from the records, if staff members had received sufficient training to do their job role effectively.

The provider told us staff were now enrolled on training courses via the on-line training system social care TV. They showed us a sample of on-line records. All of the on-line records we looked however showed that staff had not yet commenced this training. A copy of each staff member's human resource (HR Record) information confirmed this. This information also stated what training was outstanding for each staff member. On almost all of the records we looked at, the staff member had been identified as requiring training in moving and handling and medication administration.

We saw evidence that all staff members had received an induction into their job role but little evidence that staff had received adequate supervision or had an appraisal of their skills and abilities. We asked the provider for evidence of both. We were told that there was currently no management system in place to record which staff members had received an appraisal. We were also told that the formal monitoring of staff supervisions had only just commenced. We were given the log of supervision information recorded so far.

The supervision log provided did not demonstrate staff had received adequate supervision. When we compared this to a sample of the supervision records held in five staff files, we found the log had not been accurately maintained. This meant it was impossible to get a clear picture on which staff members had received supervision. We checked a sample of HR records and saw that 14 (33%) staff members had no

dates recorded in relation to supervision. Some of these staff had commenced employment in 2011.

None of the staff files we looked at contained any evidence that the skills and abilities of the staff member had been evaluated. The majority of staff we spoke with said they had not had an appraisal or couldn't remember one being undertaken.

These examples indicate staff did not have sufficient support to ensure they were delivering care safely and to an appropriate standard to the people who lived at the home. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests.

Some of the people whose files we looked at had mental health issues that may have impacted on their ability to make informed decisions about their care.

We saw that two people's care files indicated that they lived with mental health issues. We did not see any evidence in either person's file that their capacity had been assessed or discussed with the person and any significant others involved in their care. There were also no mental health or dementia care plans or risk assessment in place to guide staff how to support the person with their mental health needs and any associated risks.

We saw that one person had regularly refused staff access to their home for support to be provided. Despite there was no evidence that the provider had talked to the person about this or assessed the person's capacity to understand the implications of their actions. During our visit on the 1 April 2016, we had serious concerns about this person's well-being and asked for a safeguarding referral to be made to the Local Authority in respect of this person's care. We returned to the service on 29 April 2016. During this visit, we were told that following the safeguarding referral, a best interest meeting had been held by social services on the person's behalf and a decision to detain the person under the mental health act for their own safety had been agreed.

One person's care plan who lived with dementia had been signed by the person to indicate that they consented to their care. During a review of their care however they had indicated to the provider that they did not understand their care plan. Despite this there was no evidence that the provider had discussed the contents of the person's care plan in a way they could understand or that they has assessed the person's capacity to consent to their own care. There was also no evidence that any other advocates or representatives for example family members or IMCAs were involved in supporting this person to make decisions about the care they required.

These examples were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to have suitable arrangements in place to obtain and act in accordance with people's legal right to consent to their care and treatment.

Inadequate

Is the service caring?

Our findings

During our inspection, we found that people's experiences of care were affected in a negative way by the lack of sufficient staff to meet their needs and by the way that the management responded to concerns about their care.

We asked the people we spoke with if anyone called them from U5 when a visit was going to be late or missed. People told us that no calls were received. This meant that people who used the service did not know if the support they needed would be provided. This did not demonstrate that the service cared that people's needs had not been met. One person told us "I panic when they are not here as I'm dying to go to the toilet". Another said "The company is terrible" and one person told us that staff providing support did not stay very long "About five minutes".

Two people we spoke with indicated that the management team did not respond to their concerns about their care in a caring or meaningful way. One person told us that the management team were not always honest about the whereabouts of staff when they were late. They said they were previously told "The carers have just walked up street" when they hadn't. They said and "(Name) is a liar". Another said that when staff were late they got told staff were "On their way" but it could be over half an hour before anyone turned up. This demonstrated that people were not always given appropriate explanations for why their planned care was not provided as agreed or preferred.

A relative we spoke with told us that they had asked for staff to ring them if they couldn't gain access to the person's home due to concerns about the person's safety but they never had. This did not demonstrate that the provider cared about this person's health and wellbeing or took practical action to ensure the concerns raised were responded to appropriately.

We saw 24 people had been asked about their views on the care they received as part of a telephone survey. We reviewed each of the surveys completed. 12 people (50%) raised concerns about late visits. This demonstrated that people's needs and preferences for how and when support was provided were not always adhered to.

For example survey comments included "Late call this morning, late again so got herself washed and dressed and done own breakfast as was hungry. Late calls happen quite a bit'; "Some calls are late, diabetic and lunch call was 2:40pm should have been 1pm, then yesterday lunch call was at 10:50am" and "If calls are late, (name) gets distressed. Didn't get tea last night till 7:45pm".

It was clear that the provider had not taken any effective action to address people's negative comments as similar feedback was made by the people we spoke with during our visit. This demonstrated that the provider had not cared to address the issues important to people who used the service.

These examples were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider failed to make every reasonable effort to meet people's

preferences or take any action to respond to people's concerns about their care.

When we asked people about the staff that visited them. All comments were positive. They said that the staff who visited them were "Lovely" and treated them kindly. People's comments included; "The staff are great. They're all lovely. They just haven't got enough (staff), "They are always willing to do something. They're very caring people". People who undertook the telephone survey, also gave high praise to the staff who looked after them. Survey comments included "Girls are good. Try hard the girls"; "Lovely girls" ; "The girls are great" and "Carers are great, really kind and are overworked so that's why they are late".

These comments demonstrated that people thought the staff that supported them were kind and compassionate in their approach.

Inadequate

Is the service responsive?

Our findings

During our visit we looked at the care plans for 17 people and a sample of their daily logs. We found a lack of person centred information in all care records we looked at. Most of the care plans we saw were focused on the tasks the staff had to complete during each visit and did not identify the person's wishes in relation to how the care should be provided.

Adequate information about people's personal care needs, daily routine, nutrition and hydration; skin breakdown; continence care and moving and handling was not always provided in their care file. Information about people's medication was poor and often contradictory. All of the care plans we looked at failed to provide sufficient detail and guidance for staff to follow in the delivery of care.

When we compared what referral information the local authority had provided in relation to people's care we found that people's care plans did not accurately detail all of people's needs and care and did not always match what the local authority and the person had requested in respect of their support.

The majority of care plans we looked at were out of date and had not been reviewed for some time. From the daily logs we saw evidence that people's needs had sometimes changed but due to a lack of care reviews, people's needs had not been reassessed and their care plan amended. This left people at risk of receiving inconsistent or inappropriate care.

This meant that the provider and registered manager had failed to protect people from the risks of unsafe or inappropriate care as an accurate record of their needs, risks and care had not been maintained. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some of the people we spoke with and a relative told us that care was not provided at a time that they wanted or for the amount of time they needed. We saw from the visit records that the planned time of people's visits often varied significantly to the actual time staff turned up to provide support. We also found that the length of people's visits were often considerably shorter than had been agreed.

We saw many examples of people receiving care at irregular times and some people received two visits close together which often meant breakfast and lunch calls and lunch and tea time visits were only a short time apart. Visits at irregular times meant that some people did not have their medicines at regular intervals, access to adequate nutrition or hydration at appropriate times and some people waited for long periods for personal care, putting their skin integrity at risk. We found that the daily logs we looked at did not show that people received the care they needed had agreed to in conjunction with the Local Authority. This meant the majority of people did not receive support in accordance with their needs and preferences.

We visited one person during our visit and had serious concerns about their welfare. When we spoke to the registered manager about this we found that the registered manager had visited the person the day before and had not picked up any welfare concerns. We also found that the registered manager had failed to notice that this person did not have a care plan or care file in their home that advised staff on the person's

needs and care. We spoke to the registered manager and provider about this, and asked them to refer this person to the local authority safeguarding team due to the concerns we had about their health and well-being.

These examples demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider failed to design care which achieved people's preferences and met their needs.

We saw that the provider had a satisfactory complaints policy in place to advise people what to do and who to complain to, should they have concerns about the service or their care. We saw two complaints recorded in the provider's complaints file which were responded to appropriately by the provider. We found evidence however that the provider did not always listen or responded to people's complaints or concerns in any meaningful way.

For example, a number of telephone surveys were undertaken with people who used the service. Half of the people surveyed raised concerns about their visit times and one relative about the person's medication but there was no evidence the provider had investigated, responded to or resolved these concerns.

Two of the people we spoke with and a relative expressed serious concerns about the quality and reliability of the care received. Both people and the relative told us they had complained many times to the provider and the local authority about the quality of the care provided but little had changed. The relative told us that had the person's care plan "Seemed to be lip service on paper". Another said "I've complained. Last time to the office in February. You may as well talk to the table".
We found no evidence that a formal record of these complaints had been made or that the provider's complaints policy had been followed.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have an effective system in place to record, handle and respond to people's complaints and where complaints had been received had failed to investigate and take proportionate action.

Inadequate

Is the service well-led?

Our findings

Shortly before we visited the service, we contacted the provider to advise that an inspection would be undertaken. The provider advised The Commission that in their own judgement the service they were providing was inadequate. Twenty four hours later they rang The Commission to advise that they had made the decision to close the service and transfer people's care to an alternative provider who could meet their needs. We advised the provider that the inspection would still go ahead as due to information of concern that we had received, we were concerned about people's immediate safety.

During our inspection, we found that there were no effective systems in place to ensure the health, safety and welfare of people using the service.

The provider told us that the quality and safety of the service had been affected by staff shortages. Despite this, we found no evidence to indicate that the provider had taken any appropriate action to address the risks to people's health and well- being or to safeguard those people whose care needs they couldn't meet.

We saw that the provider's contract with the Local Authority stated that the provider must record the action taken in respect of late or missed calls. We saw that the provider had a log for the registered manager to fill in when either a person or staff member rang the office to advise that a call was late or missed. We found however that not all late and missed visits had been recorded. When we asked the senior manager about this, they told us this information had not been properly maintained.

We found that this data was however available from the provider's call monitoring system (I-CARE). When we looked at a printout of visit information and compared this to people's daily logs we were able to easily identify where people received short visit, late and early calls or missed visits. We were also able to easily identify where staff were booked on more than one visit at the same time. It was clear that staff could not achieve the visits they were allocated at the times specified or during their working hours.

We asked the provider if they had looked at the same data we had. They told us they had not. This meant the provider had undertaken no analyses of the visits planned and those delivered to ascertain how many visits were late, missed or unachievable even though they knew that with the number of staff employed it was difficult to meet people's needs. In addition there was no evidence any action had been taken to ensure staff were physically able to achieve each of the visits or that the provider had checked staff had actually turned up to support people when they were supposed to.

During our visit, we raised serious concerns with the provider about people's safety. We identified serious concerns to the way people received care and the management of the service as a whole. We were concerned that there were immediate risks to people's health and well-being. We informed the provider of our concerns and asked them to safeguard a number of people in their care. We also asked the provider to review the care of the people who used their service and to make provisions for those people whose needs they were unable to meet with the number of staff available.

When we returned to the service on the 29 April 2016 to check on the progress made, we found little progress had been taken to ensure people were safe. We saw that 27 people who required two staff members to assist them at any one time had been referred back to the Local Authority for alternative care arrangements to be made. Little action however had been taken to review the care of the remaining 150 people who still used the service. People's medication had been reviewed but only 7 people's care had been looked at in any detail. The provider had still not looked at staffing levels in any meaningful way or used the visit data we had looked at previously to minimise the risks to people's health and welfare. This demonstrated that the provider lacked adequate management skills and abilities to manage the service safely and protect people from harm. When we looked at this data again for the month of April 2016, we found late, missed and irregular calls were still a frequent occurrence. This demonstrated that people remained at serious risk.

During our visit, we found that assessment and care planning information was inaccurate, out of date and insufficient. There were no regular care plan audits in place to check that the quality of people's care plans provided staff with clear information and guidance on people's needs and care. The senior manager said that they had audited the care plans last year and found them to be poor. They said they had reported this to the manager in place at the time of the audit. There was no evidence that any action had been taken in relation to this. This meant there was no effective system in place to check that care plans met people's health, safety and welfare needs. This placed people at risk of inappropriate and unsafe care.

We found there was no system in place to ensure people's care was reviewed regularly. Daily logs of people's care were not reviewed by senior staff to ensure people received the support they needed or to check that people's needs had not changed. People's medication administration records (MAR) kept in their own home were not checked regularly to ensure staff had administered and recorded medicines correctly and there were no regular medication audits in place to check that people received the medicines they needed when they needed them. This meant there were no effective systems in place to check that the actual delivery of care was safe and met people's needs.

The care co-ordinator told us that spot checks on staff were undertaken on a regular basis. Spot checks involved a manager/supervisor observing individual staff delivering care to a person in their own home. This checked whether staff were performing their duties to a good standard. We saw a sample of spot check records that confirmed this. There was no evidence however that the findings of the spot check were discussed with the staff member or that the provider analysed the spot checks completed across the company to identify trends or areas for improvement.

The provided did not have an effective staff management system in place that monitored the training, supervision and appraisal of staff. This meant there were no effective management systems in place to ensure staff had the skills, abilities and competencies to provide safe and appropriate care.

We saw that the provider had a quality assurance framework in place. This included called a 'balance score card'. This score card was designed to be completed regularly by manager on any service delivery risks, staff management and compliance with the Local Authority Contract. Other monitoring referred to within this policy were call monitoring and weekly management reporting. We saw no evidence that any of these quality assurance procedures had been followed.

We asked the provider for a copy of the latest score cards completed in relation to the service. We were told no score card monitoring had been completed. They were unable to explain why they had not ensured the quality monitoring framework in place had not been followed. They acknowledged it was their responsibility to do so.

The provider had failed to submit statutory notifications in relation to notifiable incidents to The Commission as required by law for example, serious injuries and safeguarding. They also failed to notify The Commission or the Local Authority of the staff shortages that impacted on the delivery of the service and the safety of people in their care.

These examples demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider failed to have effective systems and processes in place to assess and monitor the quality and safety of the service provided.

After our visit and in conjunction with the Local Authority the service was closed voluntarily by the provider and people's care transferred over to an alternative provider within 5 weeks of our initial visit. This ensured that people were safeguarded from any further risks from this service.