Nestor Primecare Services Limited

Allied Healthcare Hull

Inspection report

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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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Allied Health Care Hull is registered to provide personal care to people in the community.

This unannounced inspection took place on 30 June, 4 and 27 July 2016. A lead inspector conducted the inspection over the three days and was supported by a second inspector on 4 July 2016. At the last inspection of the service in December 2014, the service was complaint with all of the regulations we inspected at that time.

The registered manager had been in post for four months at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service did not have sufficient numbers of suitably qualified, competent, skilled and experienced to deploy. The service could not cover 430 care calls between 27 June and 3 July 2016. The service also had to permanently relinquish care packages for 17 people back to the local authority commissioners, Hull City Council as they did not have the staff meet their needs. The 17 people required an accumulative total of 567 care hours per week. People who used the service were exposed to the risk of abuse by way of neglect because the registered provider failed to ensure the service could deploy sufficient numbers of staff to meet their assessed needs.

The registered provider failed to ensure plans were in place to deal with emergency situations, including staffing shortages.

Call monitoring records showed that staff consistently failed to stay for the full duration of the care call. We saw that calls commissioned for 30 minutes were delivered in 11 minutes and those for 60 minutes were delivered in 38 minutes. Care calls were not always delivered at agreed times; records showed care staff arrived over two hours early for some scheduled calls.

During the inspection, the registered manager and care delivery director informed us they became aware, in March 2016, that records had been falsified within the service. This included the dates of when care plans for 160 people had been reviewed, and when audits had taken place for log books [records of the care and support that had been delivered] and medication administration records (MARs). As well as falsified dates of staff training, supervision and spot checks records. At the time of our inspection, three months after they became of the falsified records, no action had been taken to assess who needed a care plan review most urgently or what training staff required to ensure they were delivering care and support safely and competently.

Risks were not managed appropriately as the registered provider and registered manager were unaware of

the care needs for 160 people. This meant the service was delivering care and support that had not been planned for or risk assessed.

The service failed to audit 175 logs book and 99 people's MARs. The registered provider and registered manager had not assured themselves that people had received the care and support they had been assessed as requiring or even if they had any additional needs. They had not assessed whether people received their medicines as prescribed.

Safe recruitment practices were not followed. We reviewed 10 staff files and saw that seven staff had been offered a role within the service when only one reference had been obtained. The reference was not always from their last place of employment. Disclosure and Barring Service (DBS) checks were undertaken.

Due to the falsified records, the registered provider was not aware of the staff training updates which were required and failed to take action when they became aware of the issue in March 2016. When a review of staff files was completed, gaps in staff training and supervision were highlighted.

It was not clear if the service had gained people's consent before care and support was provided. The principles of the Mental Capacity Act 2005 were not always followed. Care plans had been signed to provide consent by people who did not have the right to do so.

People were supported to maintain their health and were encouraged to eat a healthy and nutritious diet of their choosing.

Staff were not fully aware of people's needs and did not know their preferences for how care and support should be delivered. People's preferences were not always recorded.

People did not receive effective person-centred care because they were not provided with the opportunity to discuss their strengths, abilities and level of independence

Complaints were not always responded to appropriately and the service failed to learn from the complaints they had received to improve the level of care and support delivered.

The registered provider failed to notify the CQC of specific events that occurred within the service including the falsified care and training records and the loss of staff which resulted in 180 people not having the care and support needs met.

The registered provider disbanded its internal auditing team in 2015 and failed to review the quality monitoring processes to ensure they remained effective. No auditing had occurred since October 2015 when numerous concerns were highlighted. These included not responding or handling complaints appropriately, annual reviews not completed as required, risk assessments not undertaken, financial transactions not recorded and gaps in staff training highlighted. There was no evidence to show that any of these issues had been addressed.

The registered provider failed to ensure they had maintained accurate, complete and contemporaneous records of each person who used the service. We found some people's care plans had not been reviewed since their creation in 2013 and 2014.

We found multiple breaches of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 and a breach of the Health and Social Care Act 2008 [Registration] Regulations 2009. Full information about

CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the registered provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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. Sufficient numbers of staff were not be deployed to meet the needs of the people who used the service which exposed 180 people to the risk of abuse by way of neglect.

Risks to the safe delivery of care and support were not mitigated. Plans were not in place to respond to emergency situations.

Staff were not recruited following safe recruitment practices.

People did not always receive their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective. Not all staff had completed essential refresher training to ensure they had up to date skills and knowledge.

Not all staff had received effective levels of support, supervision and spot checks.

Consent was not always obtained appropriately and the principles of the Mental Capacity Act 2005 were not always followed.

People were encouraged to eat healthily and supported to eat a diet of their choosing.

People had access to healthcare services to promote and maintain their health.

Is the service caring?

Requires Improvement

The service was not always caring. People who used the service told us they were regularly supported by different staff.

Staff did not have the opportunity to build relationships with the people they supported and were not aware of their preferences for how care and support was to be delivered.

People were not enabled to express their views regarding their care and support.

People were not always treated with dignity and respect.

Is the service responsive?

Inadequate

The service was not responsive. People did not receive personalised care that was responsive to their needs.

At the time of our inspection, the service was not aware of the care and support needs for 160 people because they had not reviewed their care packages for 12 months or more.

Complaints were not responded to appropriately or used to drive improvement within the service.

Is the service well-led?

Inadequate

The service was not well-led. The systems and processes used to mitigate risks and improve the service were inadequate.

The registered provider failed to notify the CQC of specific events that occurred within the service. Information which affected the safe delivery of care was not escalated to the registered provider in order for them to take appropriate action.

Care and support was not delivered in line with best practice guidelines because care was delivered that had not been planned for or agreed with people who used the service.

Allied Healthcare Hull

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 registered provider was 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 unannounced inspection took place on 30 June, 4 and 27 July 2016. A lead inspector conducted the inspection over the three days and was supported by a second inspector on 4 July 2016.

Before the inspection, we were contacted by the local authority commissioners, Hull City Council and attended a meeting with the registered provider due the service's inability to deliver care and support to 148 people. We reviewed all of the information we held regarding the service including notifications and previous inspection reports.

During the inspection, we spoke with eight people who used the service and two of their relatives. We also spoke with the registered manager, two care delivery directors, an acting area manager, the clinical lead, two operational managers and eight members of staff including office staff.

We looked at ten people's care plans along with the associated risk assessments and Medication Administration Records (MARs). We also looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) to ensure that when people were assessed as lacking capacity to make informed decisions themselves or when they were deprived of their liberty, actions were taken in their best interest.

We also looked at a selection of documentation pertaining to the management and running of the service. This included an audit, action plans, call time monitoring figures, recruitment information for ten members of staff, the staff training records as well as a number the registered provider's policies and procedures.

Inadequate

Is the service safe?

Our findings

When we asked people who used the service and their relatives if they felt safe, we received mixed responses. One person said, "I'm safe, the staff let themselves in but that's ok, they shout and let me know who they are." Another person said, "I have the same lady most days, I feel safe because I know she is coming." A relative said, "Our regular carer is amazing, I have complete trust in her and everything she does. I don't trust the other staff they send, they don't know what they are doing and I have to check everything so I know it's done. They don't inspire confidence and I wouldn't dare leave them alone with [name of the person who used the service] because I don't think they would do things right." Other comments included, "I don't always feel safe, I used to have regular staff but I don't seem to now. There are always new people coming and I don't know who they are" and "I'm quite deaf so I don't hear them come in most days, I turn around and someone is there and I have a shock, I do feel safe with them though, they know what they are doing and make sure I'm ok."

People told us the care staff supported them to take their medication. One person said, "They make sure I have my tablets. I would forget you see." Another person told us, "I take different medicines three times a day, they help me with them. I haven't had any problems, they order more when I'm running out; they are really good."

People told us that care staff did not always stay for the full duration of their care call. One person commented, "I have three calls a day and they never, and I mean never, stay as long as they should." They went on to say, "They aren't always on time, sometimes it's only a few minutes but other times it could be an hour. I have had times when no one has turned up at all." A relative explained, "Sometimes I have to ask the carer to leave early, if we have something to do and they have finished I ask them to go so we can get on with what we need to do." Another person said, "They [the care staff] usually arrive on time but usually go early."

Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed to meet the needs of the people who used the service. The registered manager told us that 14 members of staff had left the service over a very short period of time and they had 36 temporarily inactive staff due to sickness or holidays which had affected the service's ability to deliver all of the care packages they had been commissioned to deliver. During the period from 27 June to 3 July 2016 [seven days] the service reported to the local authority commissioners that they could not deliver 430 care calls and requested that the local authority commissioners found alternative arrangements to ensure they were covered. The registered manager told us, "We have exhausted all of our options; we have had to hand back calls [care packages] to the council [local authority commissioners] because we didn't have the staff."

The registered manager informed us the service required 30 new care staff, which included 22 staff to work during the evenings and at weekends to ensure they could fulfil all of the care packages that they had been commissioned to undertake. They said, "We have eight new staff who need to have an induction but they are not just for nights and evenings so we need to hand some people back permanently. We just do not have the staff to deliver the care when they need it." The care delivery director explained, "We have had to hand

back the people whose regular staff have left because we need to recruit, induct and train staff and we just can't do that quickly enough." Seventeen people who received a service predominately required two care staff and up to four calls each day, had to be re-allocated to another service on a permanent basis by the local authority commissioners to ensure their needs were met safely and consistently.

The above information contributed to the breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, staffing. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

The service did not have a robust or effective business continuity plan. The registered provider had a business continuity policy in place which stated each service would have completed a business continuity planning form and required 'all of the contact numbers to be checked quarterly and that the plan would be tested annually using different disaster scenarios'. When we asked the registered manager to provide us with the business continuity plan it was not available and it became apparent one had not been created. The registered manager told us, "When we realised we could not cover the evening calls, I informed my care delivery director and drafted staff from our Bridlington service" and went on to say, "I did the best I could in a very difficult situation."

During the inspection, we were provided with a business continuity plan that had been created on 4 July 2016. As this was produced retrospectively it meant policies and procedures had not been followed because a business continuity planning form was not in place and subsequently could not have been checked quarterly. It also meant that the registered provider and registered manager were not prepared to manage emergency situations.

The registered provider did not always follow safe recruitment practices. The registered provider's referencing policy [updated in September 2015], stated, 'A minimum of two references will be sought, however where it is not reasonably practical to delay the offer of employment further, a decision will be made to proceed with one reference.' We checked 10 staff files and found seven people had only one reference in place. A standard letter was contained in five of the seven files with only one reference which stated, 'whilst two requests, one original and one reminder, will be issued it is not reasonably practical to delay the offer of employment further. Therefore a decision has been made to proceed with one reference.' It was not clear why this standard form was not in all of the care files with only one reference and the reasons for accepting staff with only one reference was not consistently made clear.

We found that some people's references were not from their most recent employer. Failing to ensure suitable references have been returned to the service before offering prospective staff a role within the service, exposed people who used the service to the risk of receiving care and support from staff who were not suitable to work in the care industry.

Disclosure and Barring Service (DBS) checks were undertaken. A DBS check is completed during the recruitment stage to determine whether an individual has a criminal conviction, which may prevent them from working with vulnerable people. This helped to ensure people were supported by staff who had not been deemed unsuitable to work with vulnerable adults.

Risks were not managed to ensure people's safety. We found that people's care plans did not include all of their care needs and their log books [records of what care and support staff had provided] evidenced that staff were delivering support that had not been planned or risk assessed. Risk assessments are required to ensure staff deliver care and support in the safest way possible, taking people's personal abilities, limitations and needs into account. One person required the use of a hoist to ensure they transferred from

their wheelchair to other areas safely; staff recorded in their log books that they had used the hoist but the person's care plan failed to stipulate their moving and transferring needs and no risk assessment was in place to ensure transfers were completed safely.

One person's care plan [completed in March 2015] stated they were over 81 years old, fully mobile and their pressure area risk assessment concluded they were not at risk. When a new care plan was produced in July 2016 [by an assessor employed by the registered provider] it was recorded that the person was aged between 50 and 64, used a wheelchair and smoked. The new pressure area risk assessment concluded the person was at risk [of developing pressure related wounds]. However, the new risk assessment's mobility section was left blank even though the person used a wheelchair and it also failed to factor in that they smoked. Both of these areas would have increased the risk rating further and would have elevated the risk bracket the person was in.

Risk assessments of people's properties were conducted when they commenced the service or when they had a review. One person's assessment had been reviewed in March 2014 but had not been updated when they moved new to a new property. It was not clear from the registered provider's records when the person had moved but when a review was completed by the registered provider in July 2016 it was evident the risk assessment in their file was in relation to their old property. This meant the specific risks regarding the new property had not been assessed or mitigated.

Staff had completed an in house safe handling of medicines training but had not undertaken the local authority's contract specific training. This meant that the entire care team of 101 staff [77 active and 24 temporally inactive] had to complete this training. At the time of our inspection, the registered provider was assessing how this could be achieved whilst simultaneously continuing to deliver the care and support people required.

People did not always receive their medicines as prescribed. During the inspection, we reviewed eight people's medication administration records (MARs) and found five of them had gaps in recording or contained other errors. The registered provider's IT systems showed the MARs for 99 people required auditing as they had not been checked for three months. This meant the registered provider and registered manager had not assured themselves that people were being administered their medicines as prescribed.

The above information contributed to the breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

Staff had completed relevant safeguarding training which enabled them to recognise the signs that abuse may have occurred and informed them of their responsibilities to report any episode of potential abuse and poor care they became aware of. One member of staff said, "I've done the safeguarding training, it's all just common sense though really. If I see something isn't right, I report it to my manager and they investigate." Another member of staff told us, "Anything that happens, I tell the office then they deal with it from there."

People who used the service were not always protected from the risk of abuse and avoidable harm. This was due to the low level of accidents and incidents recorded with in the service. The care delivery director told us, "We [the registered provider] have a senior panel who review accidents and incidents and complaints, they have identified that the reporting in this service is very low." They went on to say, "We know that the staff were not recording accidents, incidents or complaints; the figures were too low compared to other branches." Only 29 accidents and incidents had been recorded across the service since December 2015. Failing to record and investigate accidents and incidents prevents effective learning from taking place and

subsequently preventable accidents and incidents can re-occur.

People were exposed to the risk of abuse because the registered provider had not established or operated systems to prevent abuse, poor care or improper treatment. The service could not provide care to 148 people from 27 June to 3 July 2016 which equated to 430 care calls. It was only due to the actions of the local authority commissioners, Hull City Council that ensured 148 people did not suffer abuse by way of neglect because they were able to ensure all the 430 care calls were covered. Internal records confirmed 49 missed calls had occurred since July 2015, 18 episodes of people not receiving their prescribed medicines since June 2015 and eight instances of financial abuse had occurred since September 2015. People who used the service suffered abuse by way of neglect and financial abuse by way of theft or misappropriation of money.

The above information contributed to the breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safeguarding service users from abuse and improper treatment. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

Requires Improvement

Is the service effective?

Our findings

People who used the service provided a range of responses when we asked them if the staff who supported them knew their needs and delivered effective care and support. One person said, "They [the staff] are alright, not too bad." A second person commented, "I have to explain what I need doing to most of them and they all do things differently." A third person said, "I think all the staff are very good at their jobs, I've never had a problem with any of them." A relative said, "The regular carer we have is amazing, I can't say enough about her, she is just fantastic but when she is away the staff they send are terrible; the care they deliver is just not up to standard."

Staff had not received effective levels of training, support and professional development. During the inspection, the registered manager and the care delivery director informed us that they became aware in March 2016 that records had been falsified within the service. The falsified records included staff training and supervision dates; the falsification of records enabled staff who did not have up to date training and who had not received appropriate amounts of supervision and mentorship to be allocated care calls. The registered provider's IT system prevented staff who did not have up to date training, and who had not received appropriate amounts of supervision, being allocated care calls. At the time of our inspection, which was over three months since the registered provider was aware records had been falsified, we found no action had been taken by them to review the staff training and supervision records to ascertain what records had been falsified and to what extent. Similarly, no action had been taken to prevent staff who did not have up to date skills and knowledge or had not received effective supervision and professional development from delivering care and support to people.

Thirty days after the commencement of our inspection on 30 June 2016 and over four months since the registered provider became aware of the falsification of records, they were still not fully aware of the staff's training requirements. On the last day of our inspection, on 27 July 2016, 13 staff files still required auditing to enable the registered provider to fully understand the training requirements of the care staff. The files that had been audited evidenced that refresher training was required in several areas. These included moving and transferring people, health and safety, management of medication, first aid, safeguarding adults, infection control and food hygiene. This meant that people were supported by staff who did not have the skills and knowledge to do so safely in line with current best practice principles. This increased the risk of their needs not being met effectively.

From the audited staff files, records confirmed 25 staff required supervision, which included three who had their last supervision in 2015. Due to the limitations of the registered provider's IT system, it was not clear if staff had received supervision on a three monthly basis as required; the information only highlighted when their last supervision occurred. Ten members of staff required a spot check of their practice; two staff had their last spot check in 2015. The registered provider had not supported staff effectively and failed to ensure staff were delivering the care people required in line with their training and best practice guidance.

After the inspection, we were informed by the registered provider that the care delivery director would provide all staff employed by the service with one to one supervision during August and September 2016. We

were also provided with training dates which were scheduled to ensure staff had up to date skills and knowledge.

The above information contributed to the breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, staffing. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

A member of staff told us, "We all knew that the old [registered] manager used to move the staff training dates on, she changed them by months and months. I don't like to say it but we have all done it." They went on to say, "Because the system won't let us allocate calls to staff who haven't had supervision or training, we had to change the dates so we could get the calls covered, otherwise people wouldn't get any care." The registered manager explained, "As soon as I became aware of it [the falsification or records] which was close to when I started in March, I escalated it to the care delivery director but not a lot has been done; we have had no operational support." The care delivery director said, "I informed my regional director and we looked at what resources we could bring in but we would have had to review 357 files to know what was accurate. Then we were told we had won the contract [with the local authority commissioners, Hull City Council] and we had to prepare for that."

The Mental Capacity Act 2005 [MCA] provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. For people in the community who needed help with making decisions, an application should be made to the Court of Protection. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service did not always work within the principles of the MCA; we found that consent to care and support was not recorded appropriately. For example, one person's care plan which was updated in April 2014 stated they had vascular dementia and were forgetful; their care plan had been signed by their friend who was defined on the care plan as their representative. When their care needs were reviewed in July 2016 the care plan stated they had vascular dementia and were forgetful but they had signed to provide consent to the care and support that was to be provided. This meant that either consent had been provided in 2014 by a person who did not have the authority to do so or in 2016 the care plan was signed by a person, who lacked capacity.

Another person's care plan had been signed in June 2015 by their sister who was defined on the care plan as their representative. Their new care plan produced in July 2016, stated the person had no impairment or disturbance of their brain and had been signed by the person to confirm their agreement with their new plan of care. There were no records to show that the person's sister had legal authority [power of attorney] to provide consent and agreement to the care plan in 2015 and included no reason why the person who had no impairment or disturbance of their brain had not signed the care plan themselves. This is in contradiction of principles one and two of the MCA, which stipulate, 'every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise' and 'a person must be given all practicable help before anyone treats them as not being able to make their own decisions'.

The above information demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, need for consent. We are currently considering our regulatory

response to this breach and will report on any action once it is completed.

People who used the service were supported by a range of healthcare professionals as required. A member of staff told us, "If we know the number, we will contact them directly, like if it is someone's doctor because these details are usually in the house. If it's a community nurse or chiropodist we will call the office and they arrange it." A relative we spoke with confirmed, "Our carer does all the running around, she will ring and arrange for a GP to visit if she thinks [name of the person who used the service] is not well."

People who used the service were encouraged to eat a healthy balanced diet. A member of staff told us, "I always try to get people to eat their five a day and make sure they drink enough, especially since it' so hot at the moment." Another member of staff said, "It depends what people have in the house, I'll make them anything they want but if it's not there I can't cook it." When we checked the log books that had been returned to the office, the meals which staff had prepared were recorded as were the amounts people had eaten and drank. However, the registered provider and registered manager had failed to assure themselves that people had eaten and drank sufficiently because they had failed to audit the log books for 175 people for over three months.

Requires Improvement

Is the service caring?

Our findings

People who used the service told us they were supported by caring staff. However, some people made it clear that staff did not always know their needs or their preferences for how care and support should be delivered. One person said, "The girls are all lovely but I see different people every week and they don't know how I like things doing." Another person said, "They [the care staff] all seem caring and will do anything I ask them too but they don't do half the things I need doing unless I tell them; I repeat myself practically every day." Other comments included, "The staff are lovely, I look forward to them coming" and "They are very nice people." Another relative commented, "The issue we have is they send all different people and we don't know them, mum doesn't know them and who wants strangers coming every day? We have to tell them what needs doing; we have spoken to the office about it but they haven't done anything about it."

People were not always treated with dignity and respect or made to feel like they mattered. We reviewed the registered provider's call monitoring system and saw that staff regularly left calls early and arrived early or late for calls. We saw instances when people who had been allocated a 30 minute call had their care and support delivered in 11 minutes. Similarly people who required a 60 minute call had care delivered in 38 minutes. A call scheduled for 10pm was delivered at 7.48pm, a call scheduled for 8am was delivered at 8.50am and call scheduled for 22.30pm was delivered at 8.51pm. Failing to provide care at agreed times meant people were not receiving the basic care and support they required such as being supported to get up or go to bed, to use the toilet or receive time specific medicines when required.

People's care plans were not accurate and failed to meet their needs. At the time of our inspection, care plans for 160 people were out of date and required reviewing. Some people's care plans had not been reviewed or updated since their creation in 2013 and 2014. We cross-referenced people's out of date care plans with their most recent log books which, provided clear evidence that staff were delivering care and support that had not been planned for.

Staff were not aware of people's preferences for how care and support was to be delivered because the service had failed to collaboratively carry out an assessment of people's needs with them or an appointed person. The registered provider had subsequently failed to design care and support with a view to achieving their preferences. People were not supported to express their views and were not actively involved in making decisions about the care to ensure the support they received was delivered in line with their preferences. People told us the care they received was inconsistent and that staff were not always aware of their needs. A member of staff told us, "The old care plans are rubbish. I am looking at them as I do the reviews and they have very little information in them and really don't have enough for the staff to deliver the care people need."

The above information demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person centred care. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

The registered provider's clinical lead told us, "We need to have a single sheet that has all the pertinent

information on, something that staff can pick up and start to understand the person they are caring for. Things like if they have a family, what they are interested in and what they have done in their lives; personal things so they can connect." They went on to say, "If they have certain routines, how they like their tea, all the little things that really matter to people."

Staff were not always able to get to know the people they supported or build relationships with them. A member of staff told us, "I get swapped around a lot and I do a lot of covering so I don't always know the people I am going to see." Another member of staff said, "I never have chance to read the care plans so I just ask people what they want doing and make sure they are happy before I leave."

People were not always treated with kindness and compassion. Staff left calls early which meant people did not receive all of the care and support they had been assessed as requiring. A member of staff told us, "I leave all my calls early; we don't have travel time in the rotas. I know how long it will take to get to my next call and leave the one I am in early to get there on time. Sometimes it's a few minutes but at the busy times of day I will leave 15 minutes early." This meant that people were not receiving the allotted time they required as stipulated by the local authority commissioners assessor.

The working practices of the service did not encourage a caring, person-centred approach. The registered provider had received complaints regarding the lack of time care staff stayed at each call but had failed to learn from this and ensure travel time was incorporated into staff rotas to ensure they could stay the allotted time and not be late for their next call. After the inspection was completed, we were informed by the registered provider that travel time had been added to staff rotas and how long staff stayed in each call would be monitored.

We reviewed the incident logs and saw that staff showed concern for people's health and wellbeing. For example, when a person who used the service had fallen, the member of staff had called for an ambulance, waited with the person and travelled to the hospital with them to ensure they were supported until their family arrived.

People's private and sensitive information was treated confidentially. We saw that care plans and other records were stored in locked filing cabinets in secure rooms at the service's offices. The registered provider had created a confidentiality policy to ensure staff were aware of when and how information could be shared. A member of staff told us, "We all have our own passwords to access the systems and depending on your job, you have different access to information; it's all quite secure."

Inadequate

Is the service responsive?

Our findings

People who used the service told us they knew how to raise concerns and make complaints. Comments included, "I have complained before, not much got done but I just ring the office when I have a problem", "I haven't had anything to complain about but I would let them know if I was unhappy with anything" and "I think I would just ring the office if I had an problem, I have called before when my carer hasn't arrived."

People confirmed they had a care plan and that they or an appointed person had been involved in its creation. One person explained, "My son helps me with everything, he answered all their [the service's assessor] questions about what I needed and when they should come." Another person told us, "My care plan is on the telephone table; I have a review every now and then and they make any changes if I need them." A relative commented, "Nana has a care plan but it's useless now, she needs a lot more help than when she started. I think the care plan says she only needs help with taking her medicines."

The registered provider was aware that care plan review dates had been internally falsified in March 2016. At the commencement of our inspection, no action had been taken to review people's needs and ensure the service were aware of the entirety of them. No work had been completed to clarify which people were exposed to the most risk and required a review more urgently than other people.

During the inspection, we found a high number of care plans had not been reviewed since they were created in 2013 and 2014. This meant the registered provider held very limited information about people's current needs. One person's care plan stated that they self-administered their medicines but it was apparent from their medication administration records (MARs) that staff were required to administer them. This failure to respond appropriately to the persons changing needs and develop accurate care plans exposed the person to the risk of not receiving their medicines as prescribed.

A person's care plan stated they required no support to move or transfer and their moving and handling risk assessment stated they had no moving and handling needs. When we reviewed their log books it was evident that staff were required to use a hoist to move and transfer the person due to their reduced level of mobility. This meant that the service did not have an accurate record of the person's needs and staff were unaware of their preferences for specific aspects of their care. The registered provider and registered manager had failed to complete a risk assessment and failed to provide relevant instructions to ensure staff could deliver care safely and effectively. Another person's care plan had not been updated when they had moved house; their environmental/property risk assessment had not been updated so the risks in relation to delivering care from their property had not been mitigated.

The above information contributed to the breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

During the inspection, the registered provider allocated resources to the service to enable reviews of people's care needs to be completed. An action plan was created and people were assessed, using a traffic

light system, to conclude how urgently they required a review. The registered provider's action plan showed 26 people had been categorised as 'red' which meant they required a review of the care needs and a new care plan producing urgently. The registered provider informed the CQC that all of the 160 people whose care plans were out of date would be reviewed by 26 August 2016. This meant that from the time the registered provider became aware of the falsified records, will have taken six months to ensure they had a clear understanding of people's needs and had developed care plans to enable staff to meet their needs effectively and safely.

People did not receive personalised care that was responsive to their needs. People or those acting on their behalf did not contribute to their reviews and were not provided with an opportunity to discuss their views in relation to their strengths and levels of independence because their reviews did not occur when required. The registered provider's IT system showed the service was at 26% compliance in relation to reviews of care plans, medication administration records and log books. The registered manager said, "I think its 180 care plans that need reviewing and updating. I don't know how long it will take to get all of them done. We are trying to prioritise who needs it doing first, from either the date it was last done or because we know their needs have changed." The care delivery director was able to clarify that 160 care plans were either out of date [not reviewed within 12 months of their creation] and/or failed to include all of the care and support needs for people because they had changed since the care plan was created. Medication administration records for 99 people and log books for 175 people [records made by staff to indicate what support had been delivered] required reviewing to ensure they had received the care and support they required.

People who used the service were exposed to the risk of abuse by way of neglect because the registered provider did not have an accurate and up to date assessment of their needs and failed to ensure care plans were in place that covered all areas of the support and care they required. Subsequently, staff were not aware of people's needs and delivered inconsistent levels of care.

The above information contributed to the breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safeguarding service users from abuse and improper treatment. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

Care plans were not used to ensure people received care that was centred on them as an individual. A person who used the service explained, "I need help to shower and that's what my care plan says. I've told the office I only want another man to help me but they send young girls round when my regular carer is off and so I don't get showered on those days. It might not seem like much but it really annoys me, I am a man and I want a man to help me."

The registered provider had a complaints policy in place that contained information regarding acknowledgement and response times as well as how the complaint would be investigated. Complaints information was provided to people at the commencement of the service and people who used the service told us they knew how to make a complaint.

The last audit of the service was completed in October 2015. The audit showed the service had only achieved 59% compliance regarding the complaints process. The audit highlighted that responses failed to cover all aspects of the complaint, provide information to the complainant to enable them to escalate their complaint if they were unsatisfied with the initial response, communicate the learning achieved and create an action plan to ensure improvements were made within the service.

The audit stated that a person who used the service had raised a complaint but had not received a response

from the registered provider. We raised this with the care delivery director who told us, "The registered manager and the auditor have now left the company so I don't know if the person was ever contacted, there is no evidence to show they were."

We reviewed the complaints received by the service and found that complaints were not used to drive quality and improvement within the service. For example, numerous people had complained that staff failed to stay for the full duration of the care call; despite this, travel time was still not built into staff rotas. One person complained about care staff turning up late, failing to stay for the full duration of the call and the attitude of the staff. The root cause of the complaint was recorded as the complainant's attitude. Another complaint raised concerns that a total of £300 was taken from their relative's property. The root cause of the complaint was recorded as, 'The client is becoming forgetful.' There was no evidence to indicate the allegations had been investigated appropriately or that action had been taken to prevent similar incidents from re-occurring.

The above information demonstrated a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, receiving and acting on complaints. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

The care delivery director told us, "The previous registered manager did not always respond to complaints appropriately but we have a system were an automated response is sent out to the person who complains and the registered manager investigates, then I have to review the response and the learning before it is sent out" and "I am confident that all complaints will be handled effectively from now on."

Inadequate

Is the service well-led?

Our findings

A relative told us, "I don't think it is well-led; the office staff never seem to know what's going on. When our regular carer is here we don't care because she is great but when she is off, the office never seem to know who is coming and we have had days when no one has turned up at all." Another relative said, "[Name of person who used the service] is disabled and can't communicate; the other week we had seven different carers in seven days. I have complained before and said we want regular staff so they can get to know [name of person who used the service] but they can't seem to organise that."

The registered provider's quality assurance systems were inadequate. A self-audit tool was commenced in May 2016; the tool required audit of two care files, two staff files and one complaint each month in each of the registered provider's services. The registered manager explained, "The [registered provider's] audit team were disbanded at the beginning of the year, it was a huge mistake in my opinion" and "There used to be a team of auditors; someone would come every six months and stay for about four days and go through everything. They would speak with the managers and staff, and review all the paper work; it was very thorough." The care delivery director told us, "When the team was disbanded, so were the audits. We only moved to the self-audit system in May [2016] so the last audits that were done in this service were in October 2015."

We saw that the audit completed in October 2015 was comprehensive and highlighted numerous issues within the service that required addressing. For example, annual reviews were not completed as required, risk assessments were not being undertaken, financial transactions were not being recorded, gaps in staff training were highlighted and complaints were not being responded to appropriately. When we asked the care delivery director if the issues highlighted with the audit had been addressed, they told us, "An action plan will probably have been created with the old registered manager and the old care delivery director but they have both left the company. I haven't seen one and I don't think any of the actions have been followed up." The registered provider failed to ensure that effective systems were in place to monitor and improve the level of service.

The service had assessed itself at 26% compliance because log books for 175 people and medication administration records for 99 people required auditing. In addition, care plans for 160 people were out of date. The registered provider failed to ensure effective systems were in place to monitor and improve the level of service. As care plans for 160 people were allowed to pass the required review date, this meant that as people's needs changed they were receiving care and support that had not been planned for. As the registered provider was not aware of people's currents needs, they were subsequently not aware of the risks and therefore had failed to mitigate the risks associated with people not receiving care and support safely.

Appropriate systems had not been implemented to ensure staff were trained appropriately or had the skills and knowledge to meet the assessed needs of the people who used the service. Records showed staff were not trained in line with the registered provider's requirements and had not received suitable amounts of supervision and one to one support. Spot checks had not been completed on all staff to ensure they delivered the care and support people required safely and effectively.

The above information contributed to the continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

The service had failed to be open, honest and transparent when mistakes occurred and ensure appropriate action was taken to rectify shortfalls in a timely way. When the registered manager and care delivery director became aware of the falsified records in March 2016 they failed to inform the CQC and the local authority commissioners, Hull City Council. An acting area manager for the registered provider told us, "There is a weekly conference call at which all of the problematic services are discussed. I haven't ever heard of any issues in Hull and if they [the registered provider's directors] knew about the issues in Hull then I'm sure resources would have been allocated." They also said, "We have processes in place but for whatever reason this service has slipped through and cheated the figures."

In response to a request for information sent by the CQC, the registered provider's nominated individual stated, "Once the HCC [Hull City Council] contract was in place and the new branch structure had been recruited to accordingly, a full review of care plans would take place." In essence, this statement meant the management of the new contract and the recruitment of new staff would have increased the time that people had out of date care plans that no longer reflected their needs and left people who used the service exposed to the risks of not having the care and support needs met.

CQC registration requirements including the submission of notifications were not fulfilled. The registered provider failed to notify CQC of the falsified records, significant staffing issues abuse and allegations of abuse by way of neglect and theft, misuse or misappropriation of money missed calls and when people failed to receive their prescribed medicines. It is a requirement of registration that the registered provider notifies the CQC of specific events to enable their regulatory functions to be carried out.

The above information contributed to the breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, Notification of other incidents. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

Complete and contemporaneous notes were not held of each person who used the service. The registered provider's nominated individual confirmed on 8 July 2016 that care plans for 160 people were out of date and needed to be reviewed. During the inspection, we found examples of care plans that had not been reviewed since their creation in 2013 and 2014. One person no longer lived at the address the care plan stated and a risk assessment of their new property had not been created. Another person's care plan did not contain reference to required specialised equipment, which staff had recorded they used on a daily basis nor did it provide guidance to enable the staff to deliver consistent, safe and effective care.

The above information contributed to the continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

Staff told us they knew how to raise concerns regarding the service and understood they would be protected under the registered provider's whistle blower policy. A member of staff told us, "We raised our concerns with head office; we knew things weren't right and we have worked really hard to make sure everyone was getting the care they needed but we were really struggling."

As demonstrated throughout this report the registered provider had failed to ensure compliance with regulations 9, 11, 12, 13, 16, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014 and regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The above information demonstrated a breach of regulation 8 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, general. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Notifications were not submitted to the Commission as required.

The enforcement action we took:

We followed our enforcement policy and issued a notice of proposal to vary the conditions of the registered provider's registration as a service provider and remove this location. However, this was retracted when we found satisfactory improvements had been made.

Regulated activity	Regulation
Personal care	Regulation 8 HSCA RA Regulations 2014 General Regulations 9, 11, 12, 13, 16, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009 were not being complied with.

The enforcement action we took:

We followed our enforcement policy and issued a notice of proposal to vary the conditions of the registered provider's registration as a service provider and remove this location. However, this was retracted when we found satisfactory improvements had been made.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who used the service did not receive care and support that was appropriate, met their or reflected their preferences.

The enforcement action we took:

We followed our enforcement policy and issued a notice of proposal to vary the conditions of the registered provider's registration as a service provider and remove this location. However, this was retracted when we found satisfactory improvements had been made.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent

Care and treatment was provided to people who used the service without appropriate consent being in place.

The enforcement action we took:

We followed our enforcement policy and issued a notice of proposal to vary the conditions of the registered provider's registration as a service provider and remove this location. However, this was retracted when we found satisfactory improvements had been made.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service did not receive safe care and treatment. Reasonably practicable steps were not taken to identify and mitigate risks.

The enforcement action we took:

We followed our enforcement policy and issued a notice of proposal to vary the conditions of the registered provider's registration as a service provider and remove this location. However, this was retracted when we found satisfactory improvements had been made.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People who used the service were not protected from the risk of abuse and improper treatment.

The enforcement action we took:

We followed our enforcement policy and issued a notice of proposal to vary the conditions of the registered provider's registration as a service provider and remove this location. However, this was retracted when we found satisfactory improvements had been made.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not always responded to appropriately and were not used to drive improvement within the service.

The enforcement action we took:

We followed our enforcement policy and issued a notice of proposal to vary the conditions of the registered provider's registration as a service provider and remove this location. However, this was retracted when we found satisfactory improvements had been made.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

Systems and processes were not established and operated effectively to assess, monitor and improve the quality and safety of services provided to people who used the service.

The enforcement action we took:

We followed our enforcement policy and issued a notice of proposal to vary the conditions of the registered provider's registration as a service provider and remove this location. However, this was retracted when we found satisfactory improvements had been made.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, skilled and experienced persons could not be deployed to meet the needs of the people who used the service.

The enforcement action we took:

We followed our enforcement policy and issued a notice of proposal to vary the conditions of the registered provider's registration as a service provider and remove this location. However, this was retracted when we found satisfactory improvements had been made.