Rapid Response Home Care Ltd

Rapid Response Home Care

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

Summary of findings

Overall summary

We inspected this service on 31 July and 1 August. This was an announced inspection and we telephoned 48 hours' prior to our inspection in order to arrange home visits and telephone calls with people who use the service.

Rapid Response Medical provides personal care and support to people living in their own homes in Stafford and the surrounding areas, Staffordshire Moorlands and Telford. The provider also operates an ambulance transport service from this location. This inspection visit relates to the personal care and support service only. At the time of our visit, 67 people were receiving a service.

There was no registered manager for the personal care and support service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had recently recruited a manager who was working their second week at the service. They told us they would be applying to register with us.

We found several breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service was not safe, effective, caring, responsive or well led. The overall rating for this service is Inadequate which means it will be placed into special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the 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 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. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

There were insufficient staff available to ensure people received timely support. People told us their calls were often late or rushed and staff did not have sufficient time to get between calls. Staff did not always

feel they were listened to and were concerned that staff morale was low due to high staff turnover. Staff did not always receive effective training and support to fulfil their role.

People's medicines were not always managed safely. The provider did not have effective systems to continually assess, monitor and improve the quality and safety of the service. They relied on their electronic care management system which was not always effective and did not have any additional checks to ensure people received their planned care. The provider had acted on feedback received from people about their care. However, they had not monitored the improvements made to check that they had not been effective. Complaints made to us showed that people were still receiving a poor quality service. The provider did not always meet their responsibility to notify us promptly of important events that occurred in the service.

Staff did not always follow the legal requirements when people lacked the capacity to make certain decisions. However, staff understood the importance of gaining consent where people had capacity to make their own decisions.

People had good relationships with the staff that supported them on a regular basis. However, the lack of available staff meant that people did not always know who would be visiting them and they did not always feel respected by these staff. Some people's preferences for their choice of who provided their care were not always met. Staff were not always able to support people in a timely way to ensure they were engaged in activities that promoted social inclusion.

Risks associated with people's care and home environment were assessed and managed. Staff understood their responsibilities to protect people from the risk of abuse and were confident any concerns reported to the provider would be acted on. However, some staff were unsure of how to escalate concerns to the local authority safeguarding team if they needed to. The provider followed recruitment procedures to ensure staff were suitable to work in a caring environment.

People's privacy and dignity was promoted and staff encouraged them to be as independent as they wished. People managed their own healthcare needs but staff supported them to access other health professionals if required. Where needed, people were supported to have sufficient amounts to eat and drink.

People did not feel their concerns and complaints were listened to and acted on. People did not always feel they were supported to have a care plan that reflected their agreed support needs.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 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.

There were insufficient staff to meet people's support needs in a timely way. People did not always receive their medicines as prescribed. Staff knew how to recognise and report potential abuse but were not sure how to escalate concerns to the local safeguarding team if needed. Risks to people were identified and staff knew what action to take to keep people safe. The provider followed recruitment procedures to ensure staff were suitable to work in a caring environment.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff understood the importance of gaining consent where people had the capacity to make their own decisions. However, the provider was not following the legal requirements where people lacked the capacity to make certain decisions for themselves. Staff did not always receive effective training and support to carry out their role. People were offered support with meals and drinks and to access healthcare professionals if needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us they were happy with the staff they saw on a regular basis. However, the lack of available staff meant that people did not always know the staff that visited them and did not always feel they were treated with respect. People told us the staff respected their dignity, gave them choice about their daily routine and encouraged them to be as independent as they wished.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Concerns and complaints were not always dealt with. Some

people's preferences for their choice of who provided their care were not always respected. Staff were not always able to support people in a timely way to ensure they were supported to engage in activities that promoted social inclusion.

Is the service well-led?

Inadequate

The service was not well-led.

The provider did not have effective systems in place to continually assess, monitor and improve the service. The provider sought feedback on the quality of the service but action taken had not been monitored to ensure it had been effective. Complaints raised with us showed that people had continued to receive a poor quality service. Staff did not always feel listened to when they raised concerns about the service. The provider did not always notify us of important events that occurred in the service. There was no registered manager but a new manager had started working at the service who intended to register with us.

Rapid Response Home Care

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 July and 1 August 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service. We wanted to arrange home visits and telephone calls to people who used the service and to ensure staff were available to speak with us. The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We had received information of concern from the local authority and people who used the service that calls were being missed and people's specialist needs were not being met. We reviewed statutory notifications the provider had sent us about important events that occurred in the service and spoke with commissions who arrange services on behalf of people. We used all this information to formulate our inspection plan.

On this occasion, we had not asked the provider to submit a provider information return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, we gave the provider the opportunity to share information they felt was relevant with us.

We visited three people who used the service and their relatives. We also telephoned 11 people who used the service and their relatives. We spoke with the provider, the training manager and five care staff. We reviewed records held at the service's office, which included seven people's care records to see how their care and treatment was planned and delivered. We reviewed staff files to see how staff were recruited, trained and supported to deliver care appropriate to meet each person's needs. We looked at the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement.

Inadequate

Is the service safe?

Our findings

We had received information from the local authority and people using the service that there were not enough staff to meet people's needs. People and relatives told us and records confirmed their calls were frequently late and calls had been 'missed'. One person told us, "They were over two hours late this morning and didn't let me know. I'm supposed to have two staff in the morning and at night but sometimes they only send one because they are so short of staff. Sometimes nobody has been at all". We checked the records for this person and saw that two calls had been missed and on ten occasions, the agency had only sent one member of care staff. The person's relative told us, "The carers have been so late sometimes, we've supported [Name of person] ourselves". Another relative told us, "If they send just one carer I have to help out. I've complained and asked them, what would happen if [Name of person] had no help but as yet they haven't given me an answer". We saw that this person received a call from only one member of care staff on nine occasions when they should have had two staff. A third relative told us, "We have two calls a day. We never know when they are coming and on one occasion they told us they were short staffed and couldn't get somebody to us until very late so I told them it wasn't worth them coming". We looked at the call records for this person and saw that their calls were late on six occasions in the last two months.

We also found concerns with the provider's call monitoring system which raised alerts if people did not receive their planned support. On the day of the inspection, we received further information from the local authority that a person had not received one of their calls and had been left without their medicines. The person's social worker had referred these concerns to the local authority safeguarding team for investigation. We discussed this with the provider and found that the person concerned had not received a bedtime call because there had been an error with the system. The provider's care management system had not alerted them to this because the call had been cancelled and the person had been left without support. We were also informed by a person's relative that this had had occurred with their relation's calls and their lunchtime visit had been cancelled due to an error made on the earlier scheduled call. The provider told us they had identified that this was a problem with the care management system. However, they did not show us how they were taking action to resolve this with the provider of the system. This meant these people were at risk of not receiving personal care and medicines essential to their health and well-being.

People and relatives told us a lot of staff had left the service. One person told us, "The last few months have been atrocious. The good carers are leaving and the remaining carers are not reliable. They are constantly late and rushed. The agency simply does not have enough staff to do their jobs effectively". Prior to the inspection, the provider had notified us that they were handing back seven packages of care to commissioners. They confirmed an increase in staff numbers was required to meet the needs of the people they were supporting. The service had experienced a very high number of staff resignations during the last two months. One member of staff told us, "Carers are leaving right, left and centre and we've lost good carers". Staff told us they had difficulty covering all the calls on their rota. One member of staff said, "I'm always late. Calls are back to back, rotas don't have any gaps in them for travelling time, so you can't stay the full time of the call if you want to finish before midnight". This meant people were at risk due to

insufficient staff to meet people's assessed needs.

The above evidence represents a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the lack of available staff had an impact on the timing of calls and some people did not always receive their medicines when they needed them. We visited a person who received their medicines through a percutaneous endoscopic gastrostomy (PEG) because they had swallowing difficulties. They told us, "My medicines are time critical and I need my calls every four hours. The staff frequently arrive too early or too late, which means I can be in pain, which affects my functioning". We checked the records and saw that the on four occasions in the last two months, intervals between calls had been too long. For example, on one occasion the calls had been more than two hours late, which meant the person had been placed at risk of not having their pain managed. These issues were being investigated by the local authority safeguarding team. Another person told us, "I depend on the staff to administer my medicines. Very often this is administered late because the agency don't have enough staff to guarantee punctuality. This puts me at risk because I take medicines for my heart and for pain relief". Records showed that the person's calls had been more than 60 minutes late on five occasions in the last two months and meant that this person was at risk of not receiving their medicines as prescribed. The person was being supported by their social worker to move to another agency.

We found that the provider did not always have safe systems to ensure people received their medicines as prescribed. We saw when people had been prescribed a course of antibiotics, the provider did not always ensure that the information was loaded onto their electronic care management system promptly. For example, for one person the information was not updated until two days later. This meant that staff did not always have the information they needed to ensure that they administered people's medicines as prescribed. Staff told us that when people's medicines changed they would contact the office for clarification. However, we saw that staff did not consistently follow this procedure. For example, a member of staff told us, "One person had been prescribed a course of penicillin which wasn't on the system. I contacted the on-call chemist for advice. I noticed that carers had been in and administered the medicine although it wasn't recorded on the system and they hadn't checked with management". The records showed that one member of staff had reported the new medicine to the office but there was no evidence to show that the system had been updated at this point. At the next three calls, staff recorded that all medicines had been administered. However, they had not recorded if they had administered the penicillin or sought advice from the office. This meant we could not be assured that this person received their medicines as prescribed. We discussed this with the provider who could not provide an explanation as to why the care management system had not been updated when the new medicine had been brought to their attention.

The above evidence represents a breach of Regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe with the staff but did not always know who was coming to see them. One relative told us, "We haven't had a rota since the beginning of June and that didn't always tell us anything as it said 'unknown' for the second carer, which I assume was where they didn't have a member of staff available". Checks of other people's rotas confirmed these comments. People and relatives told us new staff had usually been introduced to them by another care worker. However, one relative told us the staff did not always show their ID badge when they came to the door. They told us, "We've seen a lot of different staff over the last month or so and although any new ones are usually introduced to us by a familiar member

of staff, it's important that they do this. My daughter is always telling me not to let anybody in without seeing their identification first".

Staff understood their responsibilities to keep people safe from abuse. They were able to identify the different types of abuse and told us they would not hesitate to report their concerns to the office. One member of staff told us, "I'd report anything that was different and follow up to check something had been done". However, some staff were not aware of how to escalate their concerns to the local safeguarding team if they felt appropriate action had not been taken. We brought this to the attention of the provider and acting manager. Discussions with the provider and acting manager demonstrated that safeguarding concerns were referred to the local safeguarding team for investigation. However, we found that these concerns were not always notified to us in accordance with the requirements registration with us.

We saw that risks associated with people's care and their home environment had been assessed and plans were in place to guide staff on how to minimise these risks. Records we looked at showed that plans were in place to guide staff on how to minimise these risks. For example, plans were in place where people were at risk of developing sore skin due to pressure damage. However, we saw that mobility care plans did not identify where people required the support of two care staff. One person's relative told us their relation received the support of two care staff for support getting in and out of bed but this was not stated on their mobility care plan. The provider told us their care planning system did not have this facility but the need for 'doubles', ie where two staff were required was detailed in their rota planner, which showed that the person required the support of two staff. The provider agreed that this should be clearly stated on the care plan to ensure staff had the information they needed to support the person safely. Discussions with staff demonstrated that they understood people's needs and knew how to support them to minimise any identified risks.

The provider told us recruitment for new care workers was ongoing and eight applicants had been offered positions and recruitment checks were underway. We saw the provider obtained references from previous employers and a check was carried out with the Disclosure and Barring Service, which keeps records of criminal convictions. Staff we spoke with confirmed that they had been unable to start work until all these checks had been completed. This showed us the provider followed the necessary procedures to demonstrate staff were suitable to work in a caring environment

Requires Improvement

Is the service effective?

Our findings

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When 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. Staff told us that some people they supported did not have capacity to make decisions for themselves. One person's care records showed that the person's mental capacity had not been assessed correctly, for example the assessment did not identify what decision was being considered or who had been involved . The form simply stated that the person 'lacked capacity'. We saw that the person's relative had been asked to consent to their care. However, the assessment did not state that the person had given their relative approval to make decisions on their behalf, for example through a power of attorney authorisation. This meant there was no evidence that they had the legal authority to do so. Another assessment had been fully completed apart from identifying the decision being considered. We saw that the person's relative had signed to consent to their care. The consent form identified that a power of attorney authorisation was in place but there was no evidence that it had been checked to show that the relative was legally authorised to give consent. This meant these people could not be sure that their rights were being upheld.

Discussions with staff showed that they had received a brief introduction to the Act during their induction training and we found that staff lacked understanding of the requirements of the legislation. For example, they did not know how important decisions were made in people's best interest and some staff had not heard of the deprivation of liberty safeguards (DoLs). This applies where it is necessary for people's freedom and liberty to be restricted in their best interests and is authorised by the Court of Protection for people living in their own homes. This showed us the provider was not acting in accordance with the requirements of the legislation.

The above evidence represents a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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Staff were provided with an induction and training to prepare them for their role. Staff who were new to care completed the care certificate. This is a nationally recognised qualification which supports staff to gain the skills to work in a caring environment. However, some people and their relatives did not feel staff had the knowledge and skills to provide effective care. One person told us staff did not always have training to support them with their specialist needs, "The agency are telling me that the staff are PEG trained but when they come here and see what they have got to do, they panic". A relative told us, "I do worry about the high turnover of staff. In the past a nurse from the provider's team supported new carers with on the job training that was very well organised, but she seems to have disappeared now". Staff told us they had received PEG training but this had been completed in the office by the training manager, who had received training from the Abbot nurse advisor. The Abbott nurse provides advice and training on the PEG feeding equipment. One member of staff told us, "We used to have good training and support from a qualified nurse, who would

come out with us and support with people's specialist needs. They've left now and the nurse we have now is always busy with assessments and they are also leaving". The provider told us that staff were supported to meet people's specialist needs by the nurse advisor or training manager, who accompanied them on visits to people's homes. However, they could not provide any evidence to support this. All the staff we spoke with felt staff who were new to care were not adequately trained for their role. One member of staff said, "They don't get to shadow for long enough". Another said, "Younger staff don't always recognise the importance of maintaining people's privacy, for example I have to remind them about things like closing all the blinds and curtain's at night". We saw that staff received an induction and mandatory training relevant to the needs of people supported by the service, although we noted that this did not include training in MCA and DoLS. We saw spot checks were carried out to assess their competence in areas including medicines administration, safe moving and handling and supporting people with specialist needs, for example a PEG. However, these were not up to date and some staff had not been checked since 2016 which meant the provider could not be sure that all staff were providing effective care to people.

We received mixed responses when we asked staff if they received regular supervision and appraisal. Staff told us they had not had supervision for some time but felt able to raise any concerns with a member of the provider's management team. The provider confirmed that supervision meetings had not been taking place at regular intervals due to staffing problems. This showed us that staff did not always receive appropriate support, supervision and appraisal to enable them to carry out their role.

This is a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us the staff gained their consent before supporting them. A relative told us, "Staff listen if [Name of person] says he doesn't want anything done". Staff told us they always sought people's consent before providing support. One member of staff said, "I always check people understand and give them choices, for example when I'm helping people to dress I hold up clothes from the wardrobe and check they are happy with things". This demonstrated staff understood the importance of gaining consent where people had the capacity to make their own decisions.

Where people were supported with mealtime visits, we saw that their dietary needs were assessed and monitored to ensure they were met. People and their relatives told us they were offered choice in relation to their meals and staff encouraged them to eat and drink enough to maintain good health. One person told us, "They offer me choices for my breakfast and other meals. I am always left with a drink". Staff told us they reported any concerns to the office to ensure that advice was sought from the person's GP. This showed people were supported to eat and drink sufficient to meet their dietary needs and preferences.

People were responsible for managing their own healthcare needs however staff told us they would offer support to people if they requested it. One person told us the staff referred him to his GP if he was unwell when visits take place. We also saw that staff contacted other professionals including social workers and the mental health team if they had concerns about people's wellbeing.

Requires Improvement

Is the service caring?

Our findings

We received mixed views from people and relatives when we asked them if they received support from staff who knew them well and understood their needs. People who told us they received support from a small group of carer staff said the staff were kind and caring and treated them with respect. Comments included, "We get on very well with all the care team. They are very respectful and give me sufficient privacy", and, "The carers will do anything for you". However, other people told us that the service had declined in recent months. The continual staff changes meant they did not always know who would be visiting them and the care they received could be variable. One person said, "The good carers have moved on leaving staff that are rushed and not very reliable." A second said, "There is no published rota so I don't know who is coming to see me and their time keeping is awful. They were two hours late this morning and that is not unusual. They never notify me and I get very anxious not knowing whether anyone is going to come". A relative told us, "We don't get a rota and don't know who is coming until they knock at the door. In the last 14 days we've had 11 different carers. There's no continuity; you don't them, they don't know us". They went on to tell us they didn't feel the new care staff listened to them and respected their wishes, "Occasionally we have problems with some of the new carers – they don't listen to us, they want to do it their way. One made all sorts of remarks about me, told me how I should be looking after [Name of person], what I should be giving them to eat for example. I was very put out as I've been caring for them for a long time". This showed us people were not always treated with respect and in a caring way.

People told us the staff promoted their dignity. One person told us, "The staff always close the curtains when they are supporting me with personal care. I've never felt uncomfortable". Another person told us the staff encouraged them to maintain their independence, "They allow me to do as much for myself as I can. I value that". A relative told us, "I've asked the staff to let [Name of person] do as much as they can and I've heard them encouraging him".

People told us the staff offered them choice over their daily routine and encouraged them to be as independent as they wished. One person said, "They offer me choices as to how I want to be moved, washed and dressed. They assist me to the bathroom and help me to the degree I require of them". Another said, "The staff offer me choices for my breakfast and other meals". Relatives told us the staff involved them in their family member's care. A relative told us, "The staff are very respectful and courteous with us both".

Requires Improvement

Is the service responsive?

Our findings

People and relatives told us the provider was not responsive when it came to dealing with concerns or complaints. People told us they had raised concerns and complaints with the care staff and office staff but their concerns were not listened to. One person said, "I reported concerns to the office about a carer who refused to assist me with something. The owners took no notice of my complaints". Another person told us, "I've complained about missed calls without any explanation offered other than they had no staff. The provider does not respond to calls and emails; the whole situation has caused me immense stress and on the advice of my social worker, we are looking for another care agency". A third person told us that the provider met with them to discuss their complaints about missed and late calls but they were not satisfied with the outcome. They told us, "We had an initial meeting but they refused to agree a date for a follow up meeting because basically nothing had changed and even my social worker's intervention didn't make any difference". A relative told us they had written to the provider requesting a response to a list of ten concerns, including missed calls. Initially, the provider said they had not received the letter and although they have now met with them, they feel that the majority of the issues have not been responded to and had decided to look for another care provider".

Some people had been informed by the local authority that their care needed to be transferred to another provider because the agency could not meet their needs. They told us this had not been well communicated and they had not been offered the opportunity of any discussion with the local authority or the provider. One said, "I'm being treated like an object because the agency simply does not have enough staff to do their jobs effectively. I am appalled. I feel totally ignored". The provider told us the local authority had asked them not to contact people as they would inform them by letter

We saw that the provider kept a log of complaints. However, there was no record of three of the complaints people raised with us. Staff told us and records confirmed that when people raised concerns or complaints with them, these were recorded on the provider's care management system. However, there was no record on the complaints log to show how these had been responded to. The provider told us they had not considered that these should be recorded as they were not always raised with them as formal complaints. A member of staff told us, "The management team are not taking people's calls and expect staff such as the nurse advisor to deal with things". This showed us the provider had failed to establish and operate an effective system for identifying, recording, handling, investigating and responding to complaints.

This represents a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us that the lack of available staffing meant they did not always receive personalised support, for example with regard to their choice of who provided their personal care. One person told us, "Despite the agency knowing that I do not want a male carer, they have still sent them. They are not interested in my concerns". A relative told us, "I reported to the office that we didn't want a particular carer but the agency sent them anyway. They told me it was because [Name of staff member] was

the only carer available at that time". Another person told us they did not always receive support when they needed it and were not always able to follow their interests and take part in social activities. They said, "Sometimes the carers can be so late that I miss the lunch club at the local church". This meant the person was not receiving their planned support to reduce their risk of social isolation.

We received a mixed response when we asked people if they had a care plan which was reviewed to ensure it remained relevant. Some people told us informal reviews were carried out by a member of the provider's management team. One said, "[Name of staff member] does frequent spot checks and we have informal chats about the support we receive. Another said "Name of staff member] gets involved with hands-on care and checks that we are happy with the support we receive". However, other people told us they had a care plan in place which had been reviewed but the agreed call times were frequently not achieved. They were not aware of any spot checks being carried out and were unhappy that their complaints were not being addressed by the provider. This showed us that the provider did not have suitable systems to ensure people's care and support was kept under review to ensure it continued to meet their individual needs.

Inadequate

Is the service well-led?

Our findings

We found that the provider did not always ensure they met the requirements of registration with us. We found that notifications of important events that occurred in the service were not always sent to us. For example, we saw that the provider had not notified us of six concerns that had been referred to the local authority safeguarding team. This meant we could not check that appropriate action has been taken.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

The provider had not developed effective systems to continually assess, monitor and improve the safety and quality of the service. We saw that the provider's care management system alerted them when support tasks were not completed, or staff had concerns about people. For example, if people's medicines were not available or they refused them. This meant there was a form of monitoring taking place. However, we found this was not always effective. For example, we identified that people's calls had occasionally been cancelled due to problems when their previous call had been late and changes in people's medicines had not always been actioned promptly. In addition, alerts were not always followed up promptly due to staff shortages which required staff monitoring the calls to leave the office to complete hands-on care. The provider had not developed any additional monitoring systems to ensure they had oversight of the quality and safety of the service.

The provider told us they did not carry out any supplementary checks of the medicine administration records and relied on the alerts raised by the care management system. This meant they could not be sure that they were being competed accurately. We saw that records for medicines controlled under the Misuse of Drugs legislation were recorded but the provider could not show us any evidence that these were monitored and any concerns addressed with staff. There was no procedure to guide staff on medicines related incidents. For example, one person told us that a member of staff had not reported a spillage of their medicine. The provider was not aware of this and meant they could not be sure appropriate action had been taken, for example ensuring that the person had sufficient medicine for subsequent doses. We saw that some staff did not consistently record the amount of medicine given when people were prescribed variable doses of their medicine. This meant it was not always possible to determine how much an individual had received during a 24-hour period. We also found that protocols to describe the use of medicines prescribed on a 'when required' or 'as needed' basis, were not always in place in accordance with good practice. These are needed to ensure staff have sufficient information on when the medicine was needed to ensure people received their medicines in a consistent way. This meant the provider could not be sure people were protected from the risks associated with medicines.

There were no systems in place to check that the care records were accurate and appropriately written. Staff recorded the care they provided on the provider's care management system and also in the paper records kept in people's homes. We saw that the electronic records staff made sometimes included their personal opinions and the records in people's homes contained frequent gaps or were incomplete records. The provider told us staff who monitor the care management system reviewed the notes during the day and

flag up any concerns or documentation quality issues. However, they could not provide evidence to support this. In addition, there were no checks to ensure that the documents required to be compliant with MCA were being completed where required.

People and relatives told us the management of the service had deteriorated in recent months. One relative told us, "Things were good when we started with the service but I think the management changed at Christmas and things have deteriorated since then". Another said, "At the start things were well run but you can't get in touch with them now". We saw that the provider had sought the opinions of people using the service by carrying out a survey in December 2016. We saw they had introduced changes to the monitoring of calls. However, these improvements had not been monitored to ensure they had been effective and sustained. Complaints raised with us showed that people had continued to receive a poor quality service. This showed us the systems that the provider had put in place were not effective in identifying areas of concern and driving improvements in the service.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no registered manager at the service but the provider had recruited a manager who was working at the service on the day of our inspection. They told us they planned to register with us.

Staff told us morale was low because of the high turnover of staff and new staff sometimes did not stay long. Staff told us they had not had a meeting with the provider for some time and communicated information through emails. One member of staff told us, "We regularly receive emails about the number of calls that need to be covered. I help where I can but sometimes it's not possible to do any more hours". Staff told us they felt able to give their views on the quality of the service, but did not always feel they were listened to. One member of staff told us, " We have been asking for packages to be handed back for some time and finally they are doing it". Another member of staff said, "Things were good at the start, this is a good company and the owners have started from nothing but at this point in time, they have bitten off more than they can chew. It will take a while but we just need to get back to where we were". Staff were aware of the provider's whistleblowing policy and told us they would not hesitate to use it if they needed to. Whistleblowing is when staff raise concerns about wrong doing within an organisation. However, given our concerns that the provider had failed notify us when safeguarding incidents that occurred in the service, we could not be confident that the provider would manage this effectively.

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 The provider had failed to notify us of some important events that occurred in the service. Regulation 18

The enforcement action we took:

We issued a Notice of Decision to restrict the provider from accepting new service users without our written agreement.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people were unable to consent to their care and treatment, the provider was not following the requirements of the Mental Capacity Act 2005. Regulation 11(1)

The enforcement action we took:

We issued a Notice of Decision to restrict the provider from accepting new service users without our written agreement.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the proper and safe management of medicines. Regulation 12(2)(g)

The enforcement action we took:

We issued a Notice of Decision to restrict the provider from accepting new service users without our written agreement.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving

	and acting on complaints The provider had failed to establish and operate an effective system for identifying, recording, handling, investigating and responding to complaints. Regulation 16 (1)(2)

The enforcement action we took:

We issued a Notice of Decision to restrict the provider from accepting new service users without our written agreement.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not developed effective systems to continually assess, monitor and improve the safety and quality of the service. Regulation 17(1)(2)(a)(b)

The enforcement action we took:

We issued a Notice of Decision to restrict the provider from accepting new service users without our written agreement.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient numbers of staff deployed to meet people's care and treatment needs. Regulation 18 (1) The provider had not ensured staff received appropriate support, training, supervision and appraisal to fulfil their role. Regulation 18 (2)(a)

The enforcement action we took:

We issued a Notice of Decision to restrict the provider from accepting new service users without our written agreement.