The Cura Heart Ltd

Cura Heart Wokingham

Inspection report

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Date of inspection visit:
05 June 2017

Date of publication:
17 August 2017

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

This inspection took place on 5 June 2017 and was announced. Cura Heart Wokingham provides domiciliary care services to people within their own homes. This includes a specific number of hours of support to help promote the person's independence and well-being. At the point of inspection 10 people using the service received support with personal care. Cura Heart Wokingham is a newly registered service. The service was registered with the Care Quality Commission in December 2016, and began operating in January 2017.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager also holds nominated individual responsibility as he is one of the two directors of Cura Heart Wokingham.

People were not always kept safe. Whilst staff were able to recognise signs of abuse, they were unable to identify what protocols to follow if they had any concerns. As a result notifications were, not completed when safeguarding incidents occurred. The service did not complete or record any investigations to ensure that all steps were taken to prevent any abuse happening again

Risks were not assessed to keep people safe. This meant that staff did not always know how to manage a risk should one occur.

People were not supported with their medicines by suitably trained, qualified and experienced staff. Not all staff who administered medicines had received training in medicine management. There had been no check of staff competency prior to administering medicines. Some people had not received their medicines as prescribed. The impact and risk of this was neither reported nor assessed by the service. Staff were trained in medicine management by the registered manager. He did not have the necessary qualifications or skill basis to ensure competent training was provided.

The service did not have systems in place to ensure sufficient suitably qualified staff were employed to work with people. Systems were not in place to ensure that staff were safeguarded from harm to their health. The provider did not seek information related to staff's physical and mental health prior to commencing employment.

People received care and support from staff who did not have the necessary skills and knowledge to care for them. Mandatory and specialist training had not been completed by all staff working with people, even though information provided by the registered manager prior to the inspection stated this had been completed. Staff did not have an understanding of the Mental Capacity Act, and did not know how to use the principles of this when working with people. People were not supported to have maximum choice and control of their lives. Staff may not have been able to support them in the least restrictive way possible; the

policies and systems in the service did not support this practice.

People told us communication with the service was not good and they did not feel listened to. Complaints were not investigated and not responded to. There was no evidence of any concerns being fully documented by the service, irrespective of issues being raised by the local authority.

People did not receive care that was person centred or tailored to meet their individual needs. Care plans did not contain sufficient information on how to support people, and were not reviewed. Calls were not completed for the full duration of the scheduled call. Staff were not allocated travel time between calls, which resulted in calls being shortened.

The service was not well-led. The registered manager did not have an overview of the service. Audits were not completed, nor the importance of these understood by the registered manager, as being an integral part in maintaining and developing the service. Information provided to the CQC was inaccurate and not reflective of the service.

We found a number of breaches in regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff were not provided with appropriate training, competency assessment and performance appraisals as were necessary for them to carry out the duties they were employed to perform. The provider had not established an effective system that ensured their compliance with the fundamental standards. The fundamental standards are regulations 8 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks had not been assessed and no measures had been taken to prevent people coming to harm.

Safeguarding protocols were not understood or followed.

Medicines were not administered by staff who were suitably qualified or competent to administer them.

Recruitment procedures did not meet the requirements of the regulations.

Is the service effective?

Requires Improvement

The service was not effective.

Staff were not appropriately trained or knowledgeable to carry out their duties effectively.

Staff were not supervised or offered any support to carry out their duties effectively.

Staff did not understood the principles of the Mental Capacity Act 2005 (MCA), and did not know when best interest decisions needed to be made on behalf of people who lacked capacity. The registered manager did not understand actions required under the MCA when people were having their liberty restricted.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff generally maintained privacy and dignity. They spoke with people respectfully.

Care where possible was offered by staff that met the requirements of the person's preference.

Is the service responsive?

Inadequate

The service was not responsive.

Documented care plans were not accurate or reflective of people's needs. These were task focused providing no detail of how to support people in a person-centred way.

People's needs were not reviewed or assessed as required.

The registered manager did not record complaints, although was able to accurately state how this should be managed. People were not confident that concerns would be appropriately dealt with by the provider.

Is the service well-led?

Inadequate

The service was not well led.

There were no audits completed by the registered manager to enable them to identify any issues related to the operation of the service. The registered manager did not have an overview of the service.

The registered manager provided inaccurate information to the CQC on the service, when asked for information prior to the inspection.

The provider failed to notify CQC of reportable incidents.

Cura Heart Wokingham

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.

The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the office. This inspection was carried out over one day on site, with a second day being used for telephone interviews and was completed by one inspector.

Prior to the inspection the local authority quality team were contacted to obtain feedback from them in relation to the service. As this was the first inspection of the service we were unable to refer to previous inspection reports. However, we used any local authority reports and notifications to assist with planning the inspection. Notifications are sent to the Care Quality Commission by the provider to advise us of any significant events related to the service, which they are required to tell us about by law. As part of the inspection process we also looked at the Provider Information Return (PIR). This 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. We had received the PIR for Cura Heart Wokingham, and used the registered manager's views on the service prior to visiting, to help inform the inspection process.

During the inspection we spoke with two members of staff, including the registered manager and one care staff. We attempted to make contact with the other two care staff on several occasions however were unsuccessful in speaking with them. We spoke with three people who use the service and three relatives of people who were authorised to speak with us on their behalf. In addition we received feedback from four professionals from the local authority.

Records related to people's support were seen for six of the ten people who use the service. In addition, we looked at a sample of records relating to the management of the service. Staff recruitment and supervision records for the three care staff and the administrator were reviewed.

Inadequate

Is the service safe?

Our findings

People and their relatives stated that they "in general are safe". Staff were described as "tend to turn up, although may be late… I know [name] is safe when they are here".
The service offered to people was not always safe. Staff did not have the correct training to keep people safe from risk, nor did they understand what would be perceived as a potential risk. Risk assessments are documents that are designed to keep people as safe as possible by identifying potential risks and setting actions to reduce the risks. These should be kept up to date, so that staff are aware of how to reduce the risk, or should a risk be identified, what actions to take as people's needs change. For example we found that in one person's file, the care plan stated that the person was prone to develop pressure sores due to limited mobility. A district nurse was involved in maintaining the care of the person in addition to staff from Cura Heart Wokingham. However this had not been followed up by a risk assessment to ensure that the person was supported in the most appropriate way to minimise the risk of developing pressure sores, and maintaining tissue viability. Another person who had significant health issues did not have any risk assessments in place to help staff understand how to manage the complexities of the risk associated with the person's deteriorating health. It was unclear if any harm had occurred to people as records were not well maintained.

Medicine was not always administered by staff who had the relevant training. We found that the staff team had not received appropriate training in medicine administration whilst working for the provider. The registered manager was delivering training in safe medicine management and stated he was signing off staff as competent despite having no training or qualifications in this field. We were unable to see if staff had come with the necessary skills from previous employment to illustrate knowledge. We were also unable to see any records or evidence that the manager had checked that staff administering medicines was competent to do so. We found that the care plans contained no information on the medicines staff were to be administering. For example of the six files we viewed four people required support with their medicines. The care plans stated "see nomad pack", when referring to the medicine name, dosage and time to be given. This meant that neither the staff nor the registered manager were aware of which medicines they were assisting people to take or the potential risks associated with medicine errors. Nomad refers to the packaging system used by pharmacies when supplying medicines by time to be taken. We were unable to see any medication administration records (MAR) sheets for any people to establish if there had been any errors, for example missed doses, as these were not retained in the office, but left in people's homes. The registered manager told us that these had not been collected since the service commenced operating in January 2017. For another person we found that whilst the care plan stated that they self-medicated, staff had been administering the medicines to the person. The registered manager was neither aware of this, nor knew why this had commenced. We were unable to establish the reason for staff deviating from the care plan.

Professionals we spoke with raised concerns regarding missed calls and late calls. They specifically related this to issues raised with medicine administration. We were told that people had missed medicines as staff had not arrived for calls. On other occasions there was very little gap between morning and lunchtime medicines. We raised this with the registered manager who was unable to illustrate what measures had

been put into place to prevent issues such as medicine mismanagement from occurring. People did not have risk assessments in place specifically related to medicines in their files. This was specifically concerning for one individual who's health needs meant that they were on a number of medicines that needed to be taken at specific times. The registered manager had not taken appropriate action to prevent the person from coming to harm should issues around medicines occur.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which states that care and treatment must be provided in a safe way by mitigating risk and safe medicine management.

Whilst staff we spoke with were able to describe different types of abuse they were unclear of what procedures to follow in the event of suspecting abuse. The service had been registered since December 2016; however staff had only just received training in safeguarding in May 2017. This meant that staff were working with vulnerable people without the appropriate training for five months. Furthermore, irrespective of having received training less than a month prior to the inspection, staff were unclear of what procedures to follow when suspecting abuse.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as staff did not understand the systems and processes to be used to prevent abuse or to safeguard people from abuse.

People and staff were not kept safe by the recruitment procedures used by the service. These did not ensure that suitable staff were recruited or deployed appropriately to carry out their duties. We found the provider had not obtained information about any physical or mental health conditions which were relevant to the applicant's ability to safely complete their duties. For example one person required staff assistance to transfer from bed to wheelchair. The registered manager was unaware if any staff were unable to carry out this task due to physical health problems. In addition there were no identification photographs of staff on their recruitment files. The provider had ensured that all staff had completed the disclosure and barring service (DBS) check. A DBS enables potential employers to determine whether an applicant has any criminal convictions that may prevent them from working with vulnerable people. References for staff were available on file, evidencing conduct in previous employment.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which stipulates that persons employed for the purpose of carrying out a regulated activity must meet specific requirements, which are further outlined in detail in Schedule 3 of those regulations.

The registered manager did not have effective systems in place to monitor incidents and accidents. This meant that the service were unable to note trends occurring in order to prevent similar occurrences in the future. We were unable to see records that showed people were being kept safe. We raised this with the registered manager, who was unable to evidence this to us further.

Requires Improvement

Is the service effective?

Our findings

People did not receive care from a staff team that was effectively supported by the registered manager. We found that whilst the Provider Information Return (PIR) stated that staff received regular supervision and support systems were in place to ensure they could carry out their duties most effectively, we found no evidence that these systems were in place. We asked the registered manager to show us staff supervision records, and were told that none had been completed yet. We queried how the registered manager would support his staff without the use of supervisions or raise any specific issues or commend staff, and were told this was through monthly team meetings. We requested seeing copies of the team meeting minutes, however were told that only one had occurred since December 2016 and the registered manager was unable to locate the minutes. The member of staff we spoke with reiterated that they had not had any supervisions or been a part of any team meetings as far as they could recall.

People were cared for by a staff team that had not received effective training to help support them with their role prior to them commencing work. Training identified as mandatory by the provider included: moving and handling, safeguarding, basic life support, infection control, food hygiene and information governance. Medicine management and Mental Capacity Act or Consent were not perceived as mandatory training irrespective of staff being involved in the administration of medicines. We found that all training had been completed by staff on 18 May 2017. We requested seeing evidence that staff had the necessary skills to commence employment without the provider's training, but there was no evidence that illustrated this. This meant that staff had been working for five months without the registered manager ascertaining they were competent to carry out their duties both safely and effectively. In addition, no specialist training was sought for staff that catered to the complex needs of their client group. For example, mental health, dementia, epilepsy. Although according to the PIR, the service specialised in five specific areas of dementia care, and the registered manager had stated in that document they had provided staff with the relevant training.
The staff team consisted of one registered manager, one admin staff, one care co-ordinator and two care staff. We were told that one of the care staff was currently working less hours due to some personal circumstances. In addition, the care staff did not have means of transport, which meant that either the registered manager or the care co-ordinator had to transport people between calls if these were not walking distance. Both the registered manager and the care co-ordinator had been completing calls since the service registered. We asked the registered manager if he felt he had sufficient staff to currently effectively deliver a service. He recognised that there were not enough staff employed at present, however advised us that the service was in the process of recruiting new staff. This would enable the care co-ordinator and manager to complete other duties. The registered manager felt that peoples care was not being compromised, as including both the care co-ordinator and himself, four staff were delivering care to ten people.

On speaking with the registered manager and one member of staff we found that they did not have a clear understanding of the principles of the Mental Capacity Act 2005 (MCA). No staff employed by the service had received training in the 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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. At present the service was not providing support to anyone whose liberty was being restricted.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which stipulates that staff should be competent, skilled and experienced to carry out the tasks needed, with appropriate support, supervision and training.

People reported that staff sought consent before completing personal care, although staff were task focused. They said, "They ask always oh yes, but barely stay long enough for a chat." Another person said, "They ask before doing anything but don't always stay for too long. They do the job and go." We spoke with the registered manager about this and queried whether staff had sufficient time to complete calls for the full duration and offer effective support. We were told yes. However, upon analysing the call durations and the staff rotas we found that staff were not given time to travel between calls. This meant that the calls were being reduced per visit in order to give staff the time to arrive at the next call. We spoke with the registered manager about this, who initially stated that calls were grouped together therefore travel time was not required. Upon further discussion the registered manager agreed to take this into consideration when developing future rotas, allowing staff travel time between calls.

We checked to see if people were appropriately supported and assisted with food and hydration. We found that this was provided, in line with the care documentation. However, this was not always at the time they had selected, due to the lateness of some calls.

We were unable to find information on how people's day to day health needs were being met, specifically in relation to working with external professionals e.g. GPs. The registered manager told us that they were in the process of developing relationships with professionals to help them effectively support people. Telephone numbers and addresses of GPs were included in the documents held in the office

Requires Improvement

Is the service caring?

Our findings

Staff were generally caring towards people they supported. They were described as being "polite and respectful" in conversation, although only had time for "brief chats". People generally felt that staff were respectful and maintained their dignity during periods of personal care. They described being covered up, having the curtains drawn closed and all door where applicable closed. We were told, "They are good like that". We noted that one person had specified that they wanted to be supported with personal care by female staff. We found that the service always tried to ensure this was offered. Where a female staff could not attend, the person was informed and given the opportunity to decide whether they wished the call to go ahead.

It was unclear if people had been involved in the initial assessment prior to care being provided by Cura Heart Wokingham. One person stated that the same staff, manager and senior staff were involved in the previous care provider, and that the company had "just changed names". This was reiterated by all three professionals and one member of staff also. However the company registered with CQC as a completely new legal entity. Whilst the same staff and management are involved in providing care to people under Cura Heart Wokingham as were in the previous service the documentation was not carried across to the new company. As such new documentation needed to be developed and agreed by all. There was no evidence of this having been agreed by the people receiving care. Care plans and documents associated with the person were reviewed after 72 hours of commencing the service according to the Provider Information Return (PIR). We asked the registered manager how frequently care documents were reviewed and updated, if required. We were told that to date no reviews or updates had been completed since people commenced receiving the service. For some people this meant reviews had not taken place for 6 months.

People and their representatives said that communication with the service was not always good. For example, knowing which member of staff was going to complete the call, or why someone was late. This was raised by all people and families we spoke with. We were told that if a member of staff was running late, often they were not notified. Explanations for the lateness were seldom given. One person and a relative stated that they were always concerned that staff will be late on days when the person had a busy schedule. This often led to the person feeling anxious and nervous. They stated "they [staff] have been constantly late since the beginning; it's only just got better over the last two weeks. That gives me a little less stress and worry."

The registered manager stated in the PIR for the service that they specialised in end of life care. We asked the provider to illustrate what was offered to people at this stage of their life, specifically focusing on training, staff knowledge, and specific care plans etc. We were told that the service had not yet developed this area of specialism. The registered manager stated they hoped that, with time, staff would be provided with training and this would be an area of growth for the service. The registered manager inaccurately recorded in the PIR that this was a current service offered. It was unclear if this service was being offered as the registered manager was not aware of all people's care needs.

Inadequate

Is the service responsive?

Our findings

People and their families were not always aware of how to report a complaint or a concern, and were not confident that complaints would be responded to appropriately by the provider. We found that neither the staff nor the registered manager knew the importance of recording, reporting or investigating a complaint. We asked the registered manager if they had received any complaints and were told none to date. However, conversations with professionals and people indicated that complaints had been made. These ranged from missed calls to staff not completing tasks. We observed that the registered manager had not recorded theses as complaints, although was verbally able to describe what procedures to follow should a person raise a concern.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which states that complaints must be investigated and proportionate action must be taken.

The service was not responsive to people's needs. We found that whilst each person had a care plan in place this was not detailed or sufficient to provide staff with the appropriate information on how to support people. For example the care plans were specifically task focused. One care plan read: "45 minutes for washing, dressing, transferring from bed to wheelchair". Additional information on how the support was to be given was not provided to reflect the person's likes, dislikes and preferences. Details of how to safely transfer the person to and from their wheelchair was not given. We spoke with the registered manager who stated that the care plan had been based on information given by the local authority however did recognise that the document did not contain sufficient information for staff to appropriately provide responsive care. People's needs were not regularly assessed or reviewed. One relative told us that he felt his wife did not always receive responsive care and support from the provider. He stated that not all staff were confident with using a hoist in the bathroom. This would therefore mean that if the regular staff was not in attendance "she [wife] will go without a bath for another week". The relative continued that on one occasion a morning call did not take place in the morning. Rather the member of staff completed "both the morning and lunch call simultaneously." This raised concern specifically regarding the risks associated with the husband trying to complete a transfer to assist his wife in the absence of staff attending a scheduled call, given staff were requested on the premise of him being unable to provide this level of care. The provider had failed to assess the person's needs and the skills of the staff to ensure they were able to support the person safely.
At present staff were either relying on calling management, or making decisions whilst working on how best to support people, when needs had changed. This was not responsive to people's changing needs and meant they were at risk of not receiving the most appropriate care and support. This further meant that as a result care plans were not amended and the registered manager was not aware of any person's changing needs. We asked the registered manager whether any reviews had taken place, and were told that to date no reviews of care and support packages had been completed, irrespective of the fact that these should be completed monthly in accordance with the company policy.

We looked at the call records of six of the ten people Cura Heart Wokingham provided care to and found that there were issues with regards to the length of calls of all the people whose records were reviewed. For example we found that one person should have a 30 minute call in the evenings. Over the course of one

week in May 2017 the call times ranged between 14 and 16 minutes. The same person should have a 45 minute call in the morning; during the same week one call was only 20 minutes long. For another person, a lunchtime call was 10 minutes only, when this call was scheduled as 30 minutes. During this call the staff should reposition the person, provide medicines and lunch. The registered manager agreed that 10 minutes would not enable a staff member to either fulfil all tasks or do these properly. For another person a 30 minute call was completed in 8 minutes. We checked the records for the past 3 months, and found that calls were consistently significantly shorter for all six people. This raised concerns specifically in relation to how were people received responsive care and support if call durations had been reduced so significantly.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which states that the care and treatment provided must be appropriate to meet the needs and reflect the preferences of the person.

Inadequate

Is the service well-led?

Our findings

People were not being supported by a staff team and service that had good management and leadership. Professionals we spoke with raised concerns about the service's ability to manage their current caseload and the support mechanisms and infrastructure in place to support the staff team. One professional stated that this was the last provider that they would go to, whilst another professional stated they would use the provider as a "last resort".

The registered manager was also the nominated individual of Cura Heart Wokingham. Whilst a team had been employed to oversee the day to day running of the service, with the registered manager keeping on overview of the operations, this had not been successful to date. One of the staff had left the company, whilst the care co-ordinator had to work shifts due to not having sufficient staff to complete calls. The registered manager stated that he too had to complete calls. The registered manager recognised that he had not kept an overview of the service and had only recently become involved with the service, although this was a newly registered company with CQC. This led us to question whether sufficient staff were employed by the service to carry out the duties both safely and effectively, as the registered manager was unable to fulfil his own duties.

The service was not appropriately audited by the registered manager. There were no systems in place to establish how effectively the service was operating in meeting legislation and requirements. For example, staff recruitment files were reportedly in line with the requirements of legislation. However these still failed to meet the requirements stipulated in schedule 3 of the regulations. Care plans had not been read or signed off by the registered manager as containing sufficient information on how to support people. These were not audited in relation to the needs of risk assessments and changing health needs. This meant that people were not receiving appropriate levels of support. People did not have any documentation specific to their health needs, even though of the six files we reviewed all had complex health needs including: epilepsy, catheter use, cancer, diabetes and existing pressures sores. We were unable to see evidence of staff raising concerns in relation to the limited information available on people. This therefore brings into question both management and staff understanding of what information is essential when providing care and support to people within their own homes and how risks and challenges need to be addressed.

The service had not completed any quality assurance audits, seeking feedback from people receiving the service, their families, staff, or stake holders. This meant that the registered manager was unable to effectively monitor and assess where improvements were needed and how these were to be actioned. People were not given an opportunity to raise any concerns or compliment staff in an effective way, as the registered manager had not put in place a way to offer people the opportunity to feedback.

The registered manager did not have accurate, complete records for each person using the service that were appropriately checked, updated and cross referenced. For example there were no medicine administration records held at the office for the registered manager to check in relation to safe medicine administration. Further he was unable to advise what medicines each person was taking, along with dose and frequency. The care plans failed to document this information also. We asked the registered manager if he completed

any audits specifically in relation to medicines, as he was providing staff with training and had stated he was assessing their competence. We were told that to date no audits or competency assessments had been completed. This meant that the provider could not be confident that people were being provided with safe care and treatment by a well-supported staff team.

The registered manager was not aware of calls being shortened, late or not occurring. As a result there was no action taken to address staff not adhering to schedules and tasks. We raised this with the registered manager, who acknowledged the need to hold staff and their supervisors accountable for continued failings with calls. The registered manager was advised that as he was registered with the CQC, he held ultimate accountability to ensure people's needs were being met. We found that in addition to staff not having received supervision since the service had registered in December 2016, the registered manager was unable to evidence transparency in the culture of the service. We were unable to see how staff were offered the opportunity to see how the service developed, and what initiatives the registered manager had taken to promote any service values. The registered manager was unable to show us evidence of how he reviewed the staff well-being linking this to their safe practice.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which states that systems must be in place to assess, monitor, and improve the quality of the service and compliance with the fundamental standards.

We found that the registered manager was unclear of what constituted a safeguarding event, we were not always sent required notifications relating to safeguarding incidents. In March 2017, the local authority raised a safeguarding with the provider regarding missed and late calls. The CQC were not notified of the safeguarding allegation by the registered manager. In addition, irrespective of this being raised as a safeguarding, the registered manager failed to put systems in place to monitor calls. We found that calls continued to be significantly shorter than scheduled. This raised concerns of the provider's ability to recognise safeguarding issues, and therefore look at implementing measures to prevent further risk or abuse of people who use the service.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, which stipulates that the registered person must notify CQC of any notifications without delay whilst carrying out a regulated activity.

As part of the inspection process the provider or registered manager, are required to submit to CQC information on what the service is doing to make sure they are safe, effective, caring, responsive and safe. They are also asked to explain how they aim to improve over the next 12 months. We found that the details provided by the registered manager in this document were completely inaccurate and not a true reflection of the service provided. For example, the Provider Information Return (PIR) stated that staff had very specific specialist training. This had neither been sourced nor provided. The PIR mentioned staff supervisions, monthly meetings, and monthly surgeries for staff to attend to further develop their understanding of their work were in place and occurring. We found that none of these had been arranged for staff. No managerial support had been provided to staff to enable them to carry out their roles effectively and safely. Staff were neither appropriately trained nor supervised. The PIR referred to risk assessing all aspects of a care package a person required, however we found that the registered manager had not completed any risk assessments for any of the people. We offered the registered manager the opportunity to explain why the PIR contained such inaccurate information, and were told that he had hoped we would inspect later, allowing him to put these measures into place.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider failed to appropriately notify CQC without delay of incidents that occurred whilst carrying out the regulated activity.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider did not ensure that the care and treatment was appropriate, met the needs and reflected people's preference. Regulation 9(1)(a)(b)(c)(3)(a)(b)(f)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person did not protect and safeguard people from abuse or mistreatment. Regulation 13(1)(2)(3).

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered provider did not investigate or act on a complaint in proportionate time. the registered provider did not have systems in place to appropriately record and handle complaints. Regulation 16(1)(2)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person did not have effective recruitment and selection procedures that ensured that persons employed for the purpose of carrying on the regulated activity. Not all information specified in Schedule 3 was available. Regulation 19(1)(a), (2)(a) and 3(a).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider did not have suitably qualified, skilled and competent staff deployed to safely carry out the regulated activity. Staff were not appropriately supported through supervisions and appraisals. Regulation 18(1)(2)(a)