Homebased Care (UK) Limited

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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

The inspection took place on 18,19 and 24 October 2016 and was announced. At the last inspection completed on 12 February 2014 the provider was meeting all of the legal requirements we inspected. Homebased Care (UK) Ltd is a domiciliary care service that provides personal care to people living in their own home. At the time of the inspection Homebased Care (UK) Ltd were providing services to 42 people, most of whom were older people living with dementia.

Homebased Care (UK) Ltd is registered to provide personal care services from the location of 34 Lichfield Street, Walsall, WS1 1TJ. The provider had moved from this location and had failed to amend this condition of their registration. The provider was now providing personal care from The Rock Church Centre, 27-31 Lichfield Street, Walsall, WS1 1TJ. This was the location from which we completed our inspection.

There had been no registered manager in post since February 2014. 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.

People were not protected from the risk of abuse due to the provider's failure to ensure safeguarding incidents were recognised, reported and investigated appropriately. People were protected by a staff team who did understand how to manage hazards in order to reduce the risk of harm such as injury. However, people were not sufficiently protected as accidents and incidents were not always recorded and monitored by the provider.

People were happy with the support they received with their medicines. However, records relating to the administration of medicines were not always completed clearly to demonstrate the support provided. People were supported by staff who had been recruited safely.

People felt most staff had the skills required to support them effectively. People were supported to provide consent on a day to day basis when they received care. However, where people lacked mental capacity, decisions were not always made on their behalf in their best interests in line with the Mental Capacity Act 2005.

People were given the support they needed to meet their needs around the food and drink they received. People were supported to access healthcare professionals and maintain their day to day health needs.

People were supported by a staff team who were kind and caring in their approach towards them. However, people did not feel the management team were caring in their approach. People were supported to make day to day choices about the care they received. People's privacy, digity and independence were protected and promoted by care staff.

People were happy with the support care staff provided during their care visits. However, they said the time at which they received their care visits was a concern and did not always meet their needs. People were not always fully involved in the development of their care plan. People did not always feel their complaints were heard and responded to appropriately.

People did not know who the management of the service were and they did not always feel heard by the provider. Staff felt the provider and management team had been supportive. However, they felt the quality of the service and support they received was affected by the inconsistencies in the management of the service. The provider had developed quality assurance systems, however, they were not sufficient in identifying the concerns we found during our inspection. Quality assurance systems were inadequate and were not effective in identifying areas of risk and improvements needed.

We found the provider was not meeting the regulations around safeguarding people, the need for consent, the management of the service and their registration with CQC. You can see what action we told the provider to take at the back of the full version of the report.

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 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

People were not protected from the risk of abuse due to the provider's failure to ensure safeguarding incidents were recognised, reported and investigated appropriately. People did not receive care visits at times that met their needs. Accidents and incidents were not always recorded.

People were protected by a staff team who understood how to reduce the risk of incidents related to their care and support. People were happy with the support they received with their medicines. People were supported by staff who had been recruited safely.

Is the service effective?

Requires Improvement

The service was not always effective

People's rights were not upheld by the effective use of the Mental Capacity Act 2005.

People felt most staff had the skills required to support them effectively. People were given the support they needed to meet their needs around the food and drink they received. People were supported to access healthcare professionals and maintain their day to day health needs.

Is the service caring?

Requires Improvement

The service was always caring

People were supported by a staff team who were kind and caring in their approach towards them. People were supported to make day to day choices about the care they received. People's privacy, dignity and independence were protected and promoted by care staff.

Is the service responsive?

Requires Improvement

The service was not always responsive

People told us they were happy with the support they received care and support from care staff, however, it was not always delivered at a time that met their needs and preferences. People were not always fully involved in the development of their care plan. People did not always feel their complaints were heard and responded to appropriately.

Is the service well-led?

Inadequate

The service was not well-led

People did not know who the management of the service were and they did not always feel heard by the provider.

The provider had developed quality assurance systems, however, they were not sufficient in identifying the concerns we found during our inspection. Quality assurance systems were not adequate and did not identify risks to people. The provider was in breach of legislation regarding their registration with CQC.

Homebased Care (UK) Ltd

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 18, 19 and 24 October 2016 and was announced. We gave the provider 48 hours' notice of the inspection. This is because we needed the provider to obtain consent from people using the service that they were happy to share with us their experiences about their care. We also needed to ensure someone would be as in the service provides domiciliary care. The inspection team consisted of 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.

As part of the inspection we reviewed the information we held about the service. We looked to see if statutory notifications had been sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We sought information and views from the local authority. We also reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

During the inspection we spoke with 13 people who used the service and four relatives. We spoke with the compliance manager, the quality manager, a coordinator and four care staff. We reviewed records relating to four people's medicines, four people's care records and records relating to the management of the service; including recruitment records, complaints and quality assurance.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe with the staff team. One person told us, "I'm safe. There is no problem at all". Care staff we spoke with could describe how to report abuse and how they would 'whistle-blow' if required. Whistle blowing is when staff might share concerns outside of the organisation; for example by contacting the local safeguarding authority, the police or CQC. Most staff we spoke with could describe signs of potential abuse, however this was not consistent across the staff team. Some care staff were not confident in their understanding of the signs of potential abuse.

We identified multiple safeguarding incidents during the inspection through speaking to staff and looking at records. For example; staff members treating people inappropriately. These incidents had not been reported to the local safeguarding authority and plans had not been put in place to protect people from the risk of further harm or abuse. The local authority are the lead organisation for investigating safeguarding concerns. Staff told us that concerns had been reported to management, however, they said no action had been taken. For example, we were told that a member of staff had shouted at one person and another person had been dropped from a hoist. We asked the current management team about the investigations that had been completed into these concerns. They told us they were not aware of the concerns and could find no record of the concerns having been reported to prior managers. They told us previous managers may not have recorded and investigated concerns reported by staff. We spoke with the provider about the concerns we identified and sent safeguarding alerts to the local authority following our inspection. This was in order for any relevant investigations to be completed and people to be protected from any potential risk or abuse. Although safeguarding and whistleblowing policies were in place. These were not fully understood by the staff team or embedded in the service. As a result people had not been protected from the risk of harm or abuse as appropriate action had not been taken to safeguard them.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment

People we spoke with told us their care visits were often late and not at the agreed times. One person told us, "They are very late sometimes - that's the trouble". Another person told us late calls impacted on their daily routines. They said, "If they're late, we can't get to our appointments, for example to see the GP". A third person told us sometimes late calls caused concerns with the management of their health needs, "I'm on insulin, and I've got to have meals on time. I haven't had a missed call but I've had some late calls". A fourth person told us, "I get quite upset as I have to wait so long". We looked at the time at which care staff arrived at calls and found multiple care visits were taking place later than the rota'd times. People told us sufficient numbers of staff were not always available to cover for staff absence. One person said, "They miss calls through illness and not having enough people on the job. They have problems covering but it's not very often I get missed calls." Another person told us, "They seem to have a lot of staff spread out. I don't think it's satisfactory". People told us there were insufficient numbers of staff to provide care at times that met their needs. People also told us while they were happy with the skills of their regular care staff, staff members that provided cover often did not have the skills required to meet their needs.

Staff told us there were not always sufficient numbers of care staff to cover for annual leave and sickness. We were told by staff that absence at weekends could put increased pressure on the staff team. We spoke with the provider about the concerns that were raised. They showed us that some concerns about call times had been identified by the management team and discussions had been held with staff during meetings. However, no further action had been taken by the management team to monitor call times and ensure people received the care they needed. They told us they would ensure further monitoring and action was taken to resolve the issues identified. At the time of the inspection the provider had no systems to monitor the time at which people received their care visits or to ensure people received their care visits as planned.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing

We looked at how the provider completed recruitment and pre-employment checks to ensure staff members were safe to work with people using the service. We found checks were completed including identity checks, references and DBS checks. A DBS check is a check on a staff member's potential criminal history. We did however identify that for some staff member's their start date had not been recorded accurately. This resulted in us not being able to confirm that some checks had been completed prior to the staff member's start date. We asked the provider for assurances that the checks were completed prior to their start. They told us this was the case although they were unable to confirm the start member's first date of employment. The provider was not able to confirm that employment checks were always in place before staff member's started work with people who used the service.

We looked at how the provider ensured accidents and incidents were reported and managed to reduce the risk of further injury to people. The provider told us there were no records held of any accidents or incidents within the service. While speaking to staff members we identified incidents that had arisen while providing care to people. For example, staff told us about an incident involving one person choking who had required first aid. Some staff members told us they had spoken to previous managers about incidents that had occurred and action had not been taken. Other staff members were not certain about how they would need to report accidents or incidents. When we asked one staff member to describe the process for reporting accidents and incidents they said, "I don't know". We confirmed with the provider the incidents that had arisen had not been recorded and monitored by the managmenet of the service. We did not identify any repeated preventable accidents, however, people were not being sufficiently protected by the provider.

People told us they were protected from the risk of injury by the staff supporting them. Staff we spoke with could describe the risks to people they cared for and how they tried to minimise these risks. People told us staff understood how to support them in a way that reduced the risk to them. One person told us, "I've had no falls, not here at home, because they help me in the shower, help me get dressed." Relatives also told us staff knew how to manage the risks to their family member. One relative told us staff members attention to detail was good and they ensured their family member's hearing aid was securely in place when they moved around. We found where people had specific needs such as diabetes, staff understood how to recognise any concerns and manage the risks to them. We saw risk assessments were in place in people's care plans, however, these were not always updated when people's needs changed and staff were not always aware of them. One staff member told us, "I don't think I've seen a risk assessment". Staff members did however understand the risks to the people they supported and how to minimise the risk of injury or harm.

People told us they were happy with the support they received with their medicines. One person told us, "They [staff] give me one lot of tablets and they're on time". They told us, "I'm happy. They're [staff] very good". We looked at people's medicines administration records to see if they were receiving their medicines as prescribed. We found some good practice around the administration of people's medicines. For example;

staff were aware when people who needed skin patches for pain relief these patches should be applied to a new place on the body each time they were given. This helps to ensure the medicine is effective and reduces unwanted side effects. Most of the staff we spoke with understood the support people needed with their medicines and they were aware that some people had medicines that needed to be given at a specific time. We did however find that medicines records were often incomplete and indicated that people may not have received all of their medicines as required. Managers we spoke with were not able to confirm that everyone had received their medicines as prescribed due to poor recording and medicines management systems.

Requires Improvement

Is the service effective?

Our findings

People told us care staff asked them for consent before providing them with support. One person told us, "They always ask if I'm ready before they do something". Relatives we spoke with also told us they felt staff asked for consent from their family member before providing care. One relative told us, "They do ask [my relative] always". Another relative told us, "They always ask [my relative's] permission. They sort of say 'Do you mind if I do this?'". We did however identify that people were not always consenting to their own care plans where they had capacity to provide consent. Some care plans and consent forms had been signed by representatives of the person who did not have the legal status to provide consent on behalf of the person. People we spoke with were not always aware of their own care plan. Care staff were asking people for consent before providing them with care, however, people were not always providing consent to their plan of care.

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 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 we spoke with had mixed levels of knowledge around the MCA. Some staff had a basic knowledge of the Act where others had not heard of the MCA and had no knowledge of the principles of the Act. We saw standard capacity assessments were included in people's care plans that covered various aspects of their care; for example managing their medicines. Capacity assessments were not however applied to specific decisions about people's care as required by the Act. For example; staff told us some people who lacked capacity refused their medicines yet there was no process in place for reporting refusals to management or taking any action to protect people. We also found staff did not ensure some people who lacked capacity had taken their medicines and left them out to be taken at a later time. One person was refusing medicines that were required for managing a specific health condition. This medicine needed to be taking regularly and at specific intervals to protect the persons health. Staff felt the person lacked the capacity to understand the importance of taking their medicines. Their capacity had not been assessed and no decision about their care made in their best interests in line with the Act. We raised this concern with the provider who sought medical advice about the person following the inspection.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent

People told us they thought most care staff had the skills needed to support them effectively. One person told us, "The carers I've got are marvellous! Definitely high quality and so caring". Another person told us, They [care staff] know exactly what to do. A third person said, "They are skilled enough for what they do for me". A relative told us, "[My relative] is very very satisfied. They're exceptional [care staff]". We did however receive some comments from people about care staff not having the required skills. One person said, "Can I be honest? Some aren't [skilled]". A relative told us, "The staff that do day and night visits are skilled, but the weekend and some night staff aren't properly trained. The regular ones are trained."

Staff told us there was regular training. One staff member told us, "There's always [training] going on". We saw from the training records given by the provider that regular training was provided to care staff. We received mixed views from staff around the quality of the training. Some staff told us training was very good. One staff member told us how their practical training helped them understand how people felt while receiving care. They told us, "You get in the hoist yourself to see how you feel". They said this had helped them to consider how they were supporting people and improved the care they provided. Other staff members however, told us they did not always feel confident following the training provided. One staff member told us, "I didn't get much training on medication". We were also told by a staff member they had used social media clips on safe moving and handling as they didn't feel able to support people using the training provided. We did see the provider ensured staff members had regular one to one meetings with a manager and regular spot checks were completed to check on staff performance in their role. The spot checks we looked at had not identified any areas of improvement. We shared the concerns raised by people and staff with the provider who told us they would investigate the issues. They told us that new initiatives were planned to develop staff training although these had not yet been implemented.

People told us they were happy with the support they received with their food and drink. People told us how care staff provided support specific to their individual needs. They also told us how they were given choices about the food they ate and how they liked it to be prepared. One person told us, "[Care staff] have to do [all of the cooking] for me. This morning I've had bacon, eggs and beans". Another person told us, "[Care staff] do the breakfast, but my [relative] gets lunch ready. [Care staff] put it in the microwave exactly as I want. They follow what I ask". People told us they were also given plenty to drink by care staff. One person said, "They make me a cup of tea and I've got drinks next to me so I don't get thirsty". Care staff we spoke with knew when people had special dietary needs and felt confident in their understanding of how to support people with their food and drink.

People told us they were happy with the support people received to meet their day to day health needs and to access healthcare professionals. People told us care staff were helpful to them in identifying if they may need to seek medical assistance. One person told us, "If I need a doctor, they usually ring for me". A relative told us how care staff had identified their family member had a swollen knee which enabled them to call a doctor. They told us, "I got the doctor in because her knee was swollen – the carers saw that!". They also said, "I'm very pleased with the outcome and I depend on [care staff] to spot things now". Care staff we spoke with were able to provide examples of how they supported people to meet certain health needs and to access support when needed. People were supported to access healthcare professionals and to maintain their day to day health.

Requires Improvement

Is the service caring?

Our findings

People did not feel the management of the service were caring towards them. People told us they were not always certain who was managing the service. They also told us they did not feel they were listened to and their concerns always resolved. We identified concerns that had been raised about people's safety and well-being that had not been addressed by the provider and left people exposed to potential harm and mistreatment. People told us care staff were kind and caring towards them. One person told us, "They speak to me in a very nice way". They also said, "The two [care staff] that come are very very nice". Another person said, "[My care staff member] is a very gentle person". A third person said, "Yes, they're [care staff] nice. I don't think there is one who is not nice". People told us care staff spent time with them and listened to them. A person told us, "When they come round, I tell [my care staff] anything. [They listen]". Relatives also told us they thought highly of care staff and that they were caring. One relative told us, "They also chat and are terribly polite. I was pleasantly surprised". Another relative told us, "I've got no problem with [the care staff] whatsoever, and neither has my [relative]. As a matter of fact, I can't praise them enough". Care staff told us they felt it was important to make people feel at ease and valued. One staff member told us, "When you walk in [to someone's home] you walk in with a smile". They told us how they talked people through the support they were providing to ensure they didn't 'startle' the person. We saw the provider looked at how caring staff members were and the relationships they had with people while completing regular spot checks. We saw in one check completed care staff had been praised for making one person feel at ease by singng with them. People were supported by a staff team who were caring in their approach although they were not always supported in a caring way but the management team.

People's choices around how they wished to spend their time were restricted by the time at which they received their care visit. Some people told us they were often waiting for care staff to arrive which meant they were not able to choose the time at which they completed certain activities such as when they ate or what time they went out to attend appointments. The management did not ensure the service was supporting people to make choices about their daily routines. People told us care staff gave them choices about their day to day care and understood their preferences. One person told us, "[Care staff name] knows where everything is kept and what I like to put on what to [do]". Relatives also told us people were given choices. A relative told us how their family member had set routines and told care staff what they wanted to wear. Staff we spoke with new people well and some of the choices they liked to make. People were supported to make everyday choices by the care staff team.

People also told us care staff protected their privacy and dignity while they were provided with support. One person told us, "[Care staff] do it in a respectful way, definitely. I can wash myself, they they'll do my back". Staff we spoke with were able to outline different ways in which they protected people's dignity while supporting them with personal care. One staff member told us, "When you're washing [people] you use two towels. You shut the door first." People told us care staff supported them in a way that helped to promote their independence. A person told us, "I'm pretty independent in some ways. It takes me a long time to do things but I do do them." We were told by people and relatives that staff were patient with people and enabled them to complete as much for themselves as possible. People were supported by a staff team who protected and promoted their privacy, dignity and independence.

Requires Improvement

Is the service responsive?

Our findings

People told us they did not always receive their care visits at the time they wanted them. However, they were mostly happy with the care they received from care staff while they were being supported. One person said, "They do what I want them to do and that's all I need". Another person told us, "They're here half an hour and do exactly as I want". Relatives also told us the care delivered met their family member's needs. One relative said, "They come for about half an hour. [My relative] has a wash every day, shower once or twice a week, they put cream on [person], they make [their] bed and dress [them], put on the washing machine, make breakfast. [My relative] loves them!". People did however say when they were visited by care staff who did not support them regularly, they did not always understand their needs. When discussing the time people received their calls one person told us they were happy with care but, "It's just the timing". People told us the time at which they had their care visits was not always consistent and did not meet their preferences. Some people told us this impacted on their daily lives. A person told us, "I like to get to bed at eight and sometimes they come at nine". Another person told us, "In the mornings I don't know when they're coming." They told us, "They don't tell you what time they're coming of a morning". A fourth person told us, "I don't know who's coming in and when". People did not receive the care visits at a regular time to support their day to day routines or at a time that met their preferences.

People we spoke with gave us mixed views about their involvement in the development of their care plan. Some people were fully involved. For example, one person told us, "Yes, [my care plan]'s right. It's all done with my input". Other people told us they hadn't been involved in the development of their care plan. A person told us, "I haven't seen a care plan, but there is one that they look at when they come". Another person told us they didn't remember a care plan but thought perhaps their relative may have been involved in it's development instead. We saw care plans had been developed. We saw recorded in people's care plans personal information such as the person's family members, personal interests and their likes and dislikes. We saw reviews were completed with people and care plans were updated. However, we saw that information contained within care plans was not always accurate and staff did not always have access to or involvement in care plans. One staff member told us, "I don't see many people's care plans". Where people's health needs had changed these changes were not always updated in care plans, however, staff we spoke with were aware of the person's updated support needs. Staff told us they understood people's needs by talking to the person and asking what they needed. Some staff said they were not certain how to report changes in people's needs or the care plan to management. People were not always enabled to be fully involved in the development of their care plan. Care plans did not always accurately people's changing needs.

People told us they knew how to raise a complaint if it was needed. Some people told us they had raised concerns and these had been resolved. One person told us, "I'd go to the office to discuss anything that wasn't right. We had a problem with one carer and that's been sorted". A relative told us about a concern that had been raised about a member of care staff. They told us the concern was raised with management and, "They did the right things" and the issues were resolved. Some people however told us they had raised concerns and these had not been addressed. One person told us about a recent complaint they had made. They said, "I have mentioned it to [staff name]. [They] understood and said [they'd] look into it. I don't keep

pushing but I haven't heard back". Another person told us about a complaint they'd raised about the time of their care visits. They told us, "I did say something about it and they did say they'd get back to me". They explained they had not yet received a response. We looked at the complaint records held by the provider and saw these concerns had not been recorded. We shared these issues with the provider who was not aware of the complaints raised. They confirmed they would investigate who the concerns had been reported to and would ensure there was a resolution to the issues raised.

We did see the provider had tried to proactively obtain people's feedback about the service they received in order to resolve any concerns raised. We looked at a recent feedback survey where people raised concerns about the time of their care visit, the consistency of their care staff and communication when care staff members changed. We saw the provider had recognised these complaints and had taken some steps to address the issues and follow up with people affected. However, the action taken had not been sufficient to resolve the issues as we found on going concerns during our inspection.

Inadequate

Is the service well-led?

Our findings

We saw the provider had developed quality assurance systems and had completed some audits within the service. For example; we saw that gaps in a staff member's recruitment file had been identified and explored with the staff member during a recent one to one meeting. We saw samples were taken each month from people's medicines records and daily care records and quality checks completed. Some areas of improvement had been identified from these checks; for example, inconsistent call times had been identified for some people from their daily records. We found these quality assurance and audit checks completed were not sufficient in identifying the areas of improvement we found. Where concerns had been identified by the provider insufficient action had been completed to make the required improvements.

We identified widespread complaints about the time at which people received their care visits. We found insufficient checks were being completed by the provider around the time care staff completed visits. We looked at staff rotas, daily records and visit times logged through the provider's electronic call monitoring system and found the three records often did not correspond with each other. These inaccuracies had not been identified by the provider. We looked at the visit times for some people where care visits were not recorded as being completed. We asked the provider to complete checks for certain people during the inspection to ensure planned care visits had taken place as scheduled. They confirmed that not all visits had taken place as scheduled. The provider had not developed systems to ensure people were receiving all of their care visits. We also followed up on specific complaints we received about the time at which people received their care visits. The provider had not developed systems to ensure people's call times were regularly monitored and issues were identified and resolved. The provider informed us of steps they were taking to make improvements in this area of the service. This included a new care coordinator completing daily monitoring of the time of people's care visits. These improvements had not been implemented at the time of the inspection.

The provider was not ensuring sufficient checks were in place to make sure the care people received met their needs. Checks were also not being completed to ensure the care being recorded in daily care records met people's needs. One person's care plan outlined that pressure areas should be checked by care staff and these checks were not being recorded by staff in their daily records. The management team were not able to confirm if these checks were being completed by care staff and had not identified the potential shortfall in the care being delivered to this person. There were insufficient checks in place to ensure care plans were accurately completed and reflected the care people received and required. The management team had not identified that one person's diagnosis was inaccurate and had been copied from another person's care plan. We also found clear guidelines were not available in care plans around people's needs in relation to any topical creams they had been prescribed. For example where on the body the creams needed to be applied and how frequently. While people told us they received the support they needed, medicines administration records outlined some inconsistencies around the application of these medicines. Managers were not able to confirm from people's care records if staff had administered them as prescribed and in line with people's needs. We found the recording of people's medicines administration was not clear and consistent. Some care staff completed a medicines administraton record (MAR) while other care staff recorded the administration of medicines within daily care records. Medicines administration records had

not been routinely checked for any gaps and errors. The management team had not identified these issues and completed further checks to ensure people had received the medicines they required. They had also not identified when care plans were not updated accurately following a change in the person's needs. For example, one person's needs had changed following a stay in hospital. Staff we spoke with were aware of the changes to this person's needs however the provider had not ensured the person's care plan was accurate and had been revised. The provider had not ensured an accurate and complete record of people's care was in place. They had also not ensured sufficient quality assurance checks and monitoring was in place around the records relating to people's care. The provider was not ensuring they had systems in place to ensure people received the care and support they needed to meet their needs and preferences.

People were not protected due to insufficient systems to record, report, monitor and investigate complaints and incidents of concern; including safeguarding concerns, accidents and other incidents. We found records were not always kept of complaints and significant incidents. Systems had not been developed to ensure the management team were aware of all issues and concerns that arose within the service. Systems had also not been developed to ensure all of these concerns were monitored and reviewed to ensure people were protected and actions could be taken to make improvements to the service where required.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations Good governance

The provider had a condition as part of their registration that they were able to provide the regulated activity of personal care from a specific address located in Walsall. The provider was operating the regulated activity from an alternative address which was not part of their conditions of registration. We agreed a date with the provider during the inspection by which a full and complete application for the amendment of their conditions of registration would be submitted.

This was a breach of Regulation 33 of the Health and Social Care Act 2008 Failure to comply with conditions.

There was no registered manager in place at the time of the inspection. The previous registered manager had not been active in their role since 2014. The provider had appointed new managers, however, they had not remained in service and had not registered with the Care Quality Commission. The provider had failed to ensure that an appropriate registered person was in post and managing the service. We were told by the provider a new manager had been appointed who intended to register with the Care Quality Commission. This manager was not available during the inspection and an application had not yet been submitted. We agreed a date with the provider during the inspection by which a full and complete application for registration would be submitted by the new manager.

This was a breach of Regulation 5 of the Care Quality Commission (Registration) Regulations 2009 Registered manager condition.

We identified during the inspection that the provider had failed to submit statutory notifications regarding significant incidents that had arisen in the service. For example, we identified a number of safeguarding concerns that had arisen prior to the inspection that we had not been notified about. A statutory notification is a notice informing CQC of significant events and is required by law.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Notification of other incidents

People told us they did not know who the manager of the service was. Some people told us there had been

frequent changes to the manager. One person told us, "I haven't got a clue who the manager is. They've come, lasted a month and then gone". Another person told us, "I don't know who runs the place. We've never met". A third person also said they would not know how to contact the office if needed. They told us, "I don't know who the manager is… I haven't got a phone number". People told us while they were mostly happy with the care staff and the support they received they did not always have a response when they raised issues with office staff or managers. We did however see the provider was taking steps to involve people in the service and to listen to people's views. We saw the provider had held a Black Country Service User Involvement Group meeting. During this meeting some people had raised concerns including the communication around changes in care staff. The provider had acknowledged these issues and had taken steps to make improvements however these steps had not been sufficient based on the feedback we received from people. They told us they were trying to increase the number of people involved in these groups in order to assist people in sharing their views and improve the involvement people had in the service. People did not however at present feel supported by a manager who they felt confident would listen to them and resolve any issues they had with the service.

Some staff members told us they also felt the lack of consistent leadership in the registered manager had impacted on the service. One staff member said, "There's been too much movement in the management and office staff". We were told, "Managers keep coming and going". Another staff member said, "Issues haven't been followed up" as a result of the changes. Staff did tell us that a new office team had been recruited that they had confidence in and who supported the care staff. A staff member said, "[Office staff member's name] and [office staff member's name] are really good". Another staff member said, "I'd go to [office staff member's name] if I needed support. [They] always help me". Staff did tell us they felt supported by the quality manager and compliance manager. They told us they felt these members of the organisation's management team had provided staff with support in the absence of a registered manager. One staff member said, "[Quality manager's name] is always available". Staff told us they were happy in their role and were committed to providing people with good quality care. However, some staff felt the service would be improved once a registered manager was in post.

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 5 Registration Regulations 2009 (Schedule 1) Registered manager condition The provider had failed to comply with the condition of their registration about having a registered manager in post.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to ensure CQC were notified about serious incidents as required by law.

Regulated activity	Regulation
Personal care	Section 33 HSCA Failure to comply with a condition The provider had failed to comply with the condition of their registration about the location from which they provided the regulated activity.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights were not always upheld through the provider ensuring they consented to their care plan and effectively applied the Mental Capacity Act 2005.

Regulated activity	Regulation

Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from the risk of abuse. Safeguarding incidents were not always recognised and reported to the local authority.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure people were protected through robust quality assurance and monitoring systems.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had no systems in place to ensure people received their care visits as planned and that there were sufficient numbers of staff.