Community Care Direct Limited

Community Care Direct

Inspection report

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Date of inspection visit:
19 May 2016
20 May 2016
23 May 2016

Date of publication:
17 August 2016

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 comprehensive inspection took place on 19, 20 and 23 May 2016 and was announced. At the previous inspection in November 2015 the service were rated inadequate and placed in special measures with breaches of regulations 9, 10, 11, 12, 13, 16, 17, 18 and 19. Enforcement action was taken and we served a notice that restricted the service from accepting any new service users until the necessary improvements had been made. We found that the agency had adhered to this legal requirement at the time of our inspection.

The agency provides care to people who have complex care needs such as palliative/end of life care, spinal injury and neurological conditions such as Parkinsons Disease and Multiple Sclerosis. At the time of our inspection there were 35 people using the service and 44 staff employed.

We found despite some improvements being made since our last inspection, such as an improved recording of messages in the communication book, we remained concerned that the service delivery was to suit the service and not the people receiving the service. We were also concerned that the registered manager had failed to demonstrate that they had actively listened to people and done everything possible to improve the care for people. People were still at risk of harm.

There was a registered manager in post at the time of our inspection. 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.

We found a system in place whereby the registered manager was visiting people to review their care but we did not see a system of transferring that information in the care plans to ensure the information in the care plans was up to date. We found care plans were also not being reviewed when changes occurred. Therefore, we could not be sure the information was up to date. We found that although new processes had been implemented, the information was not always being recorded appropriately.

We found the service were still not reviewing people's mental capacity.

A new on-call system had been put in place since our last inspection and a more thorough recording system of any messages received however, it was not always clear what action had been taken.

Staff told us that they have an online system in place to complete training in addition to their classroom training. Staff we spoke with told us they had received supervision in the last six months.

The registered manager had implemented new policies such as the Quality Control/Assurance Audit Record and Policy and completed survey questionnaires with staff and people who use the service. Of those returned, we could not see any evidence of learning from the comments or answers being given. We also did

not see any evidence of learning from complaints, safeguarding's or accidents.

An incident logging system had been put in place however it was not robust enough to ensure information was being recorded appropriately.

There had been an improvement to staff rotas as staff were now receiving them a week in advance. However there was still not enough staff to ensure people were safe and their needs were met in a timely way.

We looked in staff recruitment files and found there were systems in place for recruiting staff. Some people we spoke with were unhappy with the delivery of care in relation to the timings and duration of their calls.

We viewed MARS (Medication Administration Record Sheets) sheets and they were being signed when medication was administered. However, we found for one person there were gaps on occasions where the person required prescribed creams to be applied.

Staff were able to tell us what they would do in the event that they were concerned about abuse and how they would report it. Safeguarding training was being provided and the registered manager was sending in Statutory Notifications when appropriate. However, we received information of concern from the Local Authority and from another source.

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

Ensure that providers found to be providing inadequate care significantly improve.

Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made. Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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.

Risk assessments were absent or not detailed enough.

Staff were not following infection control procedures to keep people safe.

Incidents were not always being documented and risks mitigated.

There were not adequate staffing levels to ensure people were receiving care on time or for the duration of their call times.

Is the service effective?

Requires Improvement

The service is not always effective.

Service users mental capacity was not being reviewed to ensure their mental capacity was being considered.

Consent was not being documented within the care plans we viewed.

Communication systems were not always working.

There was a supervision matrix in place and staff were receiving supervision.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were not always providing care at the times convenient for the service user or for the duration of the call, arriving late or leaving the person's home earlier than planned.

The care was task focused with staff rushing from one call to the next.

Service users were not always being listened to.

Is the service responsive?

Inadequate

The service was not responsive.

Not all concerns and complaints were being followed up demonstrating the system in place was not robust.

The care being provided was not person centred. Care plans did not contain enough information regarding a person's wishes, preferences, medical information or care needs.

Care plans we viewed during our previous inspection had still not been reviewed or updated.

Is the service well-led?

Inadequate

The service was not well led.

Some people reported they were not being listened to or supported by the managers when they highlighted problems.

Systems in place were not always effective or robust. The incidents reporting system and dealing with concerns were not always being followed. We did not find a system in place of reviewing care plans when changes occurred.

Audits and surveys were being undertaken however, we did not see evidence of learning or improvements to the delivery of the service based on the findings of the information obtained.

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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 inspection took place on 19, 20 and 23 May 2016 and was announced.

The provider was given notice because the location provides a domiciliary care service we needed to be sure people we needed to speak with would be in.

We had received notifications from the provider and updates from the registered manager on a regular basis prior to our inspection. We also received questionnaires which some people using the service had completed to provide the service with feedback. A Provider Information Return was completed and sent to us dated 12 April 2016. This provided us with information about the service prior to our inspection.

We spoke to 5 people using the service and three relatives. We also spoke to staff and contacted Continuing Health Care and the Local Authority. We received information from a whistle blower with concerns prior to our inspection and also information from the Local Authority Safeguarding Team. We viewed seven care plans and other records pertaining to service users.

Inadequate

Is the service safe?

Our findings

At the last inspection we found the service was not always safe. The service were in breach of Regulation 12 Safe Care and Treatment and Regulation 19 Fit and Proper Persons Employed due to unsafe recruitment practices. The service were also in breach of Regulation 13 Safeguarding Service Users from Abuse and Improper Treatment and Regulation 18 Staffing. We found the systems in place to safeguard people were not keeping people safe. Some staff lacked safeguarding and manual handling training. People with complex health care needs did not have emergency procedures in their home for staff to act promptly and appropriately in the event of an emergency. Risk assessments were basic and not person centred and in some cases risk assessments/plans were absent. The recruitment checks in place were not robust to protect people from potential harm or abuse. The rating for this domain was inadequate.

On this inspection we looked into whether people who use the service feel safe. We found people's views were mixed. One person said "Yes, they are good to me". One person and their relative said they were concerned about staff placing them at risk and they had –'lost confidence' in them due to a staff member arriving at their home with faeces on their hands/arms. This led to the person making the decision to end their call received by the service at night.

One person who had complex health care needs and received 24 hour care in their own home told us how a staff member arrived at their home with faeces on their hands and arms. We spoke to the person, their relative and a staff member who also reported this to us. The person told us they were upset as they could smell faeces and believed they had been incontinent of faeces. The odour was the faeces on a staff member who had arrived from providing care to another person. A staff member also told us about this incident and that the person was distressed believing they had been incontinent. It was reported to us that the staff member did not seem concerned that is was unsafe practice to arrive at a person's home to deliver care with soiled hands/arms. It was evident the staff member had not worn gloves whilst delivering care to the person they had attended to previously placing themselves at risk and people at risk of cross infection. In view of this incident we were concerned not all staff were aware of the importance of following infection control hand practices including washing their hands in between their care visits to different people. We asked the registered manager what they had done about this and we were informed by the manager that as the relative of the service user had not asked that they looked into the incident as a complaint it was not investigated or looked into further. Therefore, it was not known why this incident had occurred to ensure it would not happen again.

This is a breach of Regulation 12 (1) (h) of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

We viewed staff surveys and questionnaires which contained responses from staff and people who use the service in relation to their safety. Some questionnaires were anonymous. One anonymous staff member responded that they disagreed they were informed of risks affecting individual people , another staff member responded that they disagreed they had been trained and supervised in order to respond correctly in emergency situations such as accidents and incidents, fire and emergency first aid. Another staff survey

we viewed stated "Disagree" to all risk assessments being shared with staff. We also viewed 14 questionnaires completed by people who use the service which had been completed and sent back to the service. Six questionnaires provided answers which were not in agreement with specific statements. One questionnaire completed by someone using the service stated "Disagree" to the question - "The agency have told me what to do in an emergency". A relative who was one person's main carer responded "Strongly disagree" to this question. We did not see an overall summary of the findings of the survey to demonstrate that the findings were being taken forward with action points to improve on the areas where concerns had been raised by people and staff. Therefore, we were concerned that the survey had been undertaken as a task in isolation with no areas identified of how the service needed to be taken forward to improve safety.

We viewed seven care plans and found four people out of seven had complex manual handling needs. Manual handling risk assessments/management plans were either absent or were not detailed enough. Three care plans we looked at did not contain a manual handling care plan despite them requiring hoisting and having complex care needs. One person's care plan which did contain a manual handling risk assessment informed staff that the hoist had been replaced with a stand aid and did not contain a detailed manual handling care plan for staff to follow. We spoke to staff about whether they are provided with the information they needed to be able to safely care for someone who had manual handling needs. One staff member we spoke to said – "we are given basic information". Another staff member told us that they learnt about how to care for someone from shadowing other staff more than from what is written in the care plan. They told us – "it isn't a problem as long as the person has a regular team of carers because they know what to do".

We checked Medication Administration Records and we found one person had gaps where they required prescribed creams to be applied. We did not see any documented entries to explain why the gaps were present so we therefore, we were therefore unsure if the person did have their prescribed creams applied on that day or not.

We spoke to people who required assistance from staff to be hoisted out of bed. One person told us they had regular carers and therefore, the carers were aware how to assist them. Another person told us they recently had two new staff sent to them to provide care and they had to talk them through their routine step by step as the staff had not been provided with information to know what to do. We looked at the person's care plan which had last been updated on 10 December 2015 with no detailed manual handling care plan. The person we spoke with was able to recall their routine and explain it to staff however we were concerned this was unsafe practice placing people at unnecessary risk of harm or injury in circumstances whereby people may not be able to provide instructions due to different cognitive abilities.

We looked into how incidents were reported and recorded. The registered manager told us that the procedure was that there was an incident form in each person's home for staff to complete an incident form in the event an incident or accident. We spoke to staff and asked them what they would do in the event of an incident or accident in someone's home. One staff member said – "I would phone an ambulance", another staff member told us "I would phone the office". Staff we spoke to when not familiar with an incident form and that the provider's procedure was that they should document the incident in an incident form. We viewed one incident form which had been completed by a staff member. We requested to see another incident form pertaining to an incident which we had read about in the communication book where a person had injured themselves. The registered manager told us an incident form had not been completed by the staff member who attended at the person's home and found the person injured. This meant that there were no clear records to explain fully what the staff member found when they arrived at the property. The registered manager told us the circumstances of the injury were that the person slid onto the floor from their chair. We spoke to the person who told us that they had fallen trying to get out of bed and they were on

the floor for two hours until they felt able to stand up. We also spoke to the staff member who had arrived at the person's home to find they had injured themselves and they confirmed the person had fallen onto the floor from the bed. Therefore, the service had failed to provide a contemporaneous record to ensure the circumstances of the incident had been recorded. Furthermore, the service had failed to complete a risk assessment following this incident to review the risks to the person thereby failing to do all that is deemed reasonable to mitigate risks and to reduce the risk of the same incident reoccurring. We spoke to the registered manager who told us they had asked the staff member who found the person injured to complete an incident form but the staff member refused to complete it. There had not been any further investigation into why the incident occurred or consideration to a referral to a falls team. We were concerned the system of dealing with incidents was not embedded to always keep people safe and the service was not always recording incidents to mitigate risks and keep people safe from harm.

This is a Breach of Regulation 12 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014

We viewed the communication book and found entries were there had been occasions when people had not received a care call. We found an entry which stated - "X rang to inform me she had no carer the night before". There was information written in the book to reassure us the person received an apology but there was no explanation as to why the staff member had not called or an investigation into why this had happened to mitigate the risk of the person not receiving care again in the future. Another entry stated - "X called - no one at X's home." On this occasion it stated a staff member had been put down for the call when they were unavailable due to being on annual leave. Another entry stated – "X called to say carer had not been today". Despite there being an improvement in recording of missed calls we were concerned action was not being taken to investigate the reasons for the missed calls to reduce the risk of people not receiving their care thereby placing them at unnecessary risk of harm through further missed calls. Another person told us that they had not received a care call and when they asked why, the manager's response was that the carer had called at their home but the person did not answer the door so the carer left. We viewed the communication book and found an entry detailing the person had called into the office to find out why the carer had not been. We were concerned that no attempt had been made to contact the person to find out if they were okay prior to the carer leaving the vicinity. The person told us they were reliant on the care call due to them being unwell the night previously having had treatment in hospital. We were concerned people were being placed at risk of neglect due to missed calls or late calls and staff were not following a safe checking system to make attempts to contact people who did not answer the door at the time of their care call.

One person who used the service said; "Carers are good but their calls are not timed well, I ring them to ask them what time they are coming, I have accidents, I have to wait for them and I am in a mess". Another person we spoke with said they were not receiving care calls at times they needed them so they were not eating when they needed to.

People told us staff did not have the time to remain with them for the duration of the call and were often rushing from one call to the next. One person told us - "Carers are forever rushing, they are meant to arrive between 9am and 10am but they arrive after 10am and then have to travel 15 minutes to their next call". Staff we spoke to told us they were not provided travel time in between calls. One staff member said - "It can be awkward when you are running late". Another staff member told us – "I never leave someone without providing the care they need but it would be nice to have time to sit with people but you don't, you're always running late for the next call". The care being provided was task focused. We viewed the daily records and records which stated for example – "Nothing needed" documented under the heading personal care, "porridge" documented under the heading food/diet, "water" documented under the heading fluids on one

daily record we viewed. Staff told us they were not always able to remain with the person for the duration of the call due to being late for their next call. When we asked the registered manager about late calls they told us there is a 30 minute period waiting time during which time they consider it acceptable for staff to be late for their next call. This time allowance was to suite the service and not the people receiving the service. There were not adequate staffing to ensure people always received their care at the times they needed them and for the duration of the call.

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

We looked into recruitment and checked five staff files to ensure staff had the appropriate checks prior to providing care for people. The staff files we checked contained application forms and references however one staff file did not contain details of an induction. The staff member however, told us that they had received an induction when they first started with the service. One staff member did not have a reference from their previous employer or any training certificates in their staff file but their DBS check had been undertaken. The registered manager was aware of this and told us that a reference and training certificates had been requested from the previous employer. We were informed by the registered manager that they had implemented a new system of DBS (Disclosure and Barring Service) which ensured all staff have a police check prior to providing care to ensure people are protected from abuse. We viewed this system on the office computer and found staff DBS's were being processed and renewed when the system generated an alert that a renewal was needed. We found the system highlighted staff DBS's needed renewal every three years however, we identified a flaw in the system as one staff member's DBS was last undertaken in 2010. Although it was not a legal requirement to renew a DBS we discussed with the registered manager that DBS renewals were not consistent ensuring all staff receive the same level of checks.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found that the service was not always effective. The service was in breach of Regulation 11 Need for Consent and Regulation 18 due to inadequate training. Staff were not receiving supervision or appraisals. Staff who had recently started had not had an induction. There was no management of their induction to ensure that they were trained and safe to work with people. Consent to care was not routinely obtained. One person who had no means of communication due to mental impairment did not have a mental capacity assessment to demonstrate carers are acting in her best interests. The rating for this domain was inadequate.

We found the registered manager had improved the training provided for staff as they had implemented an online training system. Staff told us they were receiving annual refresher training and they were provided with enough training for them to know what to do and to keep up to date. Staff told us they were having regular supervision and we viewed a supervision matrix which the registered manager had implemented for staff.

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 supported 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

On this inspection we checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We asked the registered manager if there were any people who lacked mental capacity. The manager confirmed all people had mental capacity and in the event a person lacked capacity they were aware of the best interests' process and Deprivation of Liberty Safeguards.

We viewed one person's care plan whose palliative condition was deteriorating but there were no records to demonstrate that consideration was being given to the person's mental capacity in line with their deterioration. Despite the registered manager informing us they would trigger a best interests process when appropriate, we could not see evidence of a system in place whereby mental capacity was being monitored or reviewed in order for the registered manager to be able to identify when it would be appropriate to request a formal mental capacity assessment and best interests process. We viewed another person's care plan whose condition was deteriorating and they had been noted to have "Full Capacity" approximately 10 months previously. We were informed by the person's relative that the person's mental capacity fluctuated according to the time of day and how unwell the person was at the time. We therefore, concluded the service were not adequately assessing or reviewing people's mental capacity.

We looked at consent to see if the service were seeking consent from people who used the service. During

the previous inspection we highlighted consent was not being sought and we found the service was in breach of Regulation 11 Need for Consent. We found the care plans we looked at had not been reviewed since our last inspection including whether people provided consent for changes to the care they received. We viewed care plans and records and found consent was not recorded as being obtained or reviewed. For example, one person whose care plan was dated 30 June 2016 stated the times of their calls were 9am, 1pm and 7pm. However, when we viewed the daily records plan sheet dated 16 July 2015 stated the times of calls were - 7.30am to 8.30am, 12.30 to 1pm and 8.30pm to 9pm. We viewed the daily logs and according to the daily logs the person was having two calls per day 7am to 8am and 11.30am to 12.30. We viewed their care plan and there were no records to confirm if the person had consented to these changes being made to the delivery plan of their care. Another person's care plan we looked at did not confirm the person had consented to the plan of delivery of care. They told us changes were made without their consent such as when new carers were sent to provide care who the person had not met previously. On staff member told us that they provided care for one person who's morning call had been gradually changed by an hour without their agreement. We spoke to the person receiving care who told us their call was meant to be 8am for an hour. They told us that the carers arrived at around five minutes past 9am each morning. The staff member told us the call time was changed to 8.30am and it is now 9am. We checked the person's care plan and viewed the daily care plan which stated - "two staff needed 8am -8.30am." The person told us that they were not informed of the changes to the morning call time or asked if they agreed to the change of time.

This was a Breach of Regulation 11 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014. The registered provider had failed to ensure that staff were working in accordance with the Mental Capacity Act 2005.

We found that the message system book contained messages from staff who were contacting the office with information. We viewed the message book and found it was not always clear whether an issue had been dealt with or by whom. For example, "Phoned in sick for tonight's shift", there was insufficient information with no name of the person who the staff member was due to visit and there was nothing entered in to explain what actioned was taken or by who. There were entries in the care plans we viewed of healthcare professionals details who were involved in the care of people who use the service.

We checked to see if people who use the service were receiving enough to eat and drink. One healthcare professional we spoke with told us they had observed a carer preparing home cooked food for one person when they carried out a routine visit to the person in their own home. The carer was observed cooking home cooked food for the person. Another healthcare professional we spoke to told us they had no concerns regarding the service. One person we spoke to who requires assistance for meals told us that they were reliant on carers to arrive to prepare food but they could not be sure what time they were going to arrive. The person told us that their relative would step in at times to provide food if the carer was late.

Requires Improvement

Is the service caring?

Our findings

At the last inspection we found that the service was not always caring and they were found to be in breach of Regulation 10 Dignity and Respect. Staff were not always providing care for the duration of the call, leaving the person's home earlier than planned. People were not included in their care planning. People informed us the times of their calls were changed without any consultation. The rating for this domain was requires improvements.

On this inspection we asked people if they felt cared for. One person told us; "They're doing their best, carers are fine". Another person said; "staff are lovely". Another person told us - "You can't fault the carers in anyway".

Some people we spoke to told us they did not feel listened to by managers and had at times not been spoken to in a respectful manner. One person said; "X shouted when they spoke to me about 10 days ago". Another person told us that they reported a missed call and were not supported when they highlighted this. We asked the registered manager about this and they told us staff are expected to phone ahead or phone the person receiving care if they are late. Another person told us that they did not feel listened to as they had requested a staff member did not return to provide care for specific reasons which they had explained to the manager but the staff member still was sent to provide care and arrived at their home.

We found entries in the communication book where people were phoning in to ask what time the carers were coming as they had either not been informed the carer was running late or of the change in the time of the call. Therefore, people were not always being included in the planning of their care or in making decisions about their care.

One person told us that they are supported to be as independent as possible as they only request that the carers do the minimum for them. Other people told us that they were not being supported in their daily lives to be independent due to the times of the calls not being right for them to be able to maintain their independence. Two people we spoke with told us they had to rely on their relatives if the carers were late or did not arrive and they did not like to do this. One person needed assistance with personal care. People who need support with personal care often do not wish to rely on their spouse or relative for personal care tasks to maintain their dignity and also to alleviate what they perceive to be a burden on their relatives. The purpose of receiving a caring service is to provide people with their independence thereby not having to rely on their family members.

This is a Breach of Regulation 10 Dignity and Respect (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked about advocacy services for people and the registered manager told us that they would put people in touch with advocacy services locally called the Sefton Pensioners Advocacy Services if needed.

Inadequate

Is the service responsive?

Our findings

At our last inspection we found the service was not always responsive. The service was in breach of Regulation 9 Person Centred Care and Regulation 16 Complaints. The system in place for receiving, handling and responding to complaints was not robust. Some people reported concerns and saw improvements but other people often reported the same complaint. People's care plans contained information about the person's care requirements but lacked information about the person's background, likes or dislikes, wishes or aspirations. The rating for this domain was inadequate.

On this inspection we checked whether staff had all the information they required to ensure they could provide person centred care. We checked one person's care plan which stated their diagnosis. When we spoke to the person receiving care we established they suffered with two other serious conditions which was not detailed in their care plan. This meant that staff providing care were not fully aware of the person's medical problems to equip them to have a thorough understanding of the person's problems overall. It is important to be aware of medical diagnoses when providing care for people to be able to identify signs of deterioration or concerns related to their health. We did not find information pertinent to the individual person's background, interests, likes/dislikes or aspirations with no improvement since our last inspection.

We found a system in place whereby the registered manager was visiting people to review their care but we did not see a system of transferring the information collected into the care plans to ensure the information in the care plans was up to date. We found care plans were also not being reviewed when changes occurred. One person's daily care plan had not been updated since 13 July 2015 when changes had occurred with the day to day routine of their care. Another two people's care plans which were dated June 2015 had also not been updated despite there being changes to their care. This meant that we could not be sure the information being provided to staff to enable them to provide care was accurate.

A staff member we spoke to told us that they were uncomfortable when call times were changed without the agreement of the person. Another staff member told us that the times of calls were being changed without the person being informed and people were not being consulted before a call time was changed. One person who received a service told us their call time was being changed to suit the service. Another person we spoke with who receives a service told us the carers were always on time. Most people we spoke with told us they were not always being involved in decisions regarding their care and changes were being made without their prior agreement. People also told us they were not kept informed of changes such as staff changes. For example, one person told us their call time was changed at an earlier time without consultation. Another person told us new staff had been sent to provide care without them knowing in advance of the call. Another person told us their call time was changed to a later time without consultation. Another person told us that they routinely phoned the office to ask what time carers were coming and at what time. We viewed the communication book and viewed there were several messages from people who use the service asking for the time they could expect a carer to arrive and to confirm who was coming to provide care. We were concerned the care being delivered was to suit the needs of the service and not to suit the needs of the person. One person told us – "I've tried to keep everyone happy but they should have consistent staff". We did see some entries in the communication book whereby staff were responding to the

needs of the people receiving care such as a staff member had returned to a person's home to provide care at the person's request as they needed assistance.

We viewed a message entry in the communication book which was from a health care professional phoning into the office asking carers to ensure they provided a person with food and a drink when they visited the person later that day. There were no further entries in the book documenting what action was then taken. It was therefore, unknown whether the person received food and drinks or if the message had been passed onto the carer providing care. We were concerned that although the message system had improved since our inspection, it was not robust enough.

We asked people if staff understood their care needs. One person told us that they had regular carers and they understood their care needs. One person told us that they no longer have set carer's who know them well which was impacting on the person as they did not feel carers understood them. We found that for people who had regular carers, staff were familiar with the person's routine and care needs. In view of the care plans and other documentation not being reviewed since our last inspection, we were concerned that in the event of staff changes and new staff arriving at someone's home they would not know how to deliver person centred care for the person.

This is a breach of Regulation 9 (1) b (3) (a) (c) (f) (g) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A relative we spoke with told us they had concerns regarding the care being provided for a person receiving a service. They told us the person had received care for two to three years from the service and had always received care by two carers, one male and female but the female carer always provided the "hands on" care. They said they were "shocked" when they walked into the room to find the male carer was providing the "hands on" care. The relative told us they expressed their dissatisfaction about male carers providing hands on care in a 'service user survey' document which we viewed during our inspection and when we contacted them they told us they made a complaint which triggered a meeting with the registered manager in their home. We viewed in the communication book dated 9 April 2016 – "X (relative) complained they didn't want a male carer for X (service user), X (registered manager) told them they couldn't take the male carer off the run". However, we could not find evidence of the complaint in the complaints file. The relative told us the registered manager produced a response by letter which detailed the number of times a male carer had visited during a care call but the registered manager had failed to understand the issue. The issue being not that a male carer was being provided on double handed calls along with a female carer but that the male carer was providing the "hands on" care. They told us that usually a male carer would be present with a female carer but the female carer always provided the hands on care.

We viewed an entry in the communication book dated April 2016 which was from a person's relative who phoned the office to make a complaint regarding a staff member. We checked the complaints file to establish what the outcome of the complaint was and to confirm the outcome of the complaint about the staff member. There were no entries in the complaints file regarding this complaint from a relative.

We were concerned that further concerns had not been investigated by the registered manager following a complaint such as a complaint made by a person and their relative regarding a staff member arriving at the home with faeces on their hands/arms. We found no evidence of the registered manager investigating this with the staff member.

This was a breach of Regulation 16 (1), (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our last inspection we found the service was not well led and there was a breach of Regulation 17 Governance. The rating for this domain was inadequate. There had not been a registered manager in post for over a year. A new manager had been employed in the service whilst we were undertaking our inspection. We found no written record made of telephone calls received during evenings and weekends that needed to be actioned by the 'on call' person.

On this inspection we found that the registered manager had made some improvements within the service since our last inspection. These included implementing an on line system for staff to receive both classroom based and online training, a staff supervision structure and matrix, service user surveys and staff surveys. The communication book in the office contained more detail and the on call system was more robust due to the staff member on call now not responding by leaving the office to provide care. There were updated policies in place. We checked the system in place for annual personal development reviews for staff and the registered manager told us this was something they were planning to implement in the next month. The registered manager told us they had focused on ensuring there was an improved staff structure and there was an improved staff culture within the service.

However, we found that the health, safety and welfare of people who used the service had still been compromised despite the improvements that had been made. People were still put at unnecessary risk of harm.

We were concerned there were no systems in place of reviewing care plans for people receiving a service. We raised this with the registered manager as we found care plans we viewed during our last inspection had not been reviewed when changes occurred. The registered manager told us they were waiting for a new person to start before writing a new care plan. We discussed that existing care plans would however, need reviewing.

We were informed by the registered manager that things were more stable within the staffing structure and the owner of the service was now not required to provide care which was previously the case due to staff shortages and had taken a "back seat". However, we found this was not the case. We received information from the Local Authority confirming the owner had been providing care for a person. During the course of our inspection we also received confirmation from another person we spoke with that they were also receiving care from the owner. We considered it unprofessional of the registered manager not to be transparent and open with us regarding the situation within the service.

We looked into the communication within the service. We viewed the staff meeting minutes from March 2016. We were concerned that the minutes provided a summary of what the registered manager wished to communicate to the staff and we did not see evidence of the registered manager involving the staff in any discussions. Furthermore we were concerned regarding the tone of the minutes which were referring to staff who were previously employed by the service that followed the whistleblowing procedures as "mischief makers". This was not an effective or professional manner in which to communicate with staff.

The registered manager told us they had reviewed their audit systems. We viewed the Quality Control/Assurance Audit Record and Policy. We viewed staff surveys which involved staff completing tick box questionnaires containing questions such as – "I am trained and supervised in order to respond correctly in emergency situations such as service user accidents and incidents, fire and emergency first aid". Not all staff agreed with this statement and ticked "disagree". There were 19 surveys returned, some of which were anonymous. We could not see how this information was then being taken forwards to ensure this was being addressed. We also viewed a quality assurance survey which involved service users completing a tick box questionnaire providing their view about their care. The questions included questions such as – "The service have told me what I do in an emergency". "Staff discuss my medication with me and I understand what I am taking and why". We found some people ticked "disagree" to questions but again we found no action points from the audit to demonstrate that the information being given by service users was being listened to and used to improve the service.

The registered manager had implemented new policies such as the incident reporting policy and a new system whereby staff were expected to complete an incident form which was in each person who uses the service's home. We asked to view the incidents/accidents file/book. The registered manager provided us with a blank incident form to be completed by staff. We therefore, asked to view an example of a completed incident form during our inspection. We were provided with an incident form dated 14 February 2016 which had been completed by a staff member. We later asked to view an incident form completed for another person who used the service but found it had not been completed for the person. We also, asked staff if they were aware of a new incident form in each person's home and found some staff we spoke with were not aware they were required to complete this form which was in each person's home. Therefore, we were concerned the system was not consistent and had not been embedded in the service to ensure staff were completing documentation. We also, did not see any evidence the registered manager was looking at trends or themes of accidents/incidents to ensure they had an overarching view of the delivery of the service.

Not all complaints made by people or relatives were being recorded or investigated with an outcome for people. This was a concern in view of the importance of learning from the experience of people receiving a service. Learning from mistakes and errors is the foundation of progressive development and improvement within a service. We found examples where the service had not actively listened to people and their relatives. This did not provide us with the confidence that the service had people's best interests at the core of their service and delivery of care. Despite the improvements cited in the report, the improvements had not been embedded effectively across the service to improve the quality of the care being provided for people. We therefore concluded the leadership and governance were ineffective.

Regulation 17 Governance (1), (2) (a), (b), (c), (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans did not contain up to date information about the person. Care plans were not person centred to reflect people's wishes and preferences.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The care being provided was task orientated. People were not always being listened to.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent During the previous inspection we highlighted consent was not being sought and we found the service was in breach of Regulation 11 Need for Consent. We found the care plans we looked at had not been reviewed since our last inspection including whether people provided consent for changes to the care they received.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service was not safe. Risk assessments were either absent or not detailed enough. Not all incidents were being recorded or risks recorded/reviewed to mitigate risks.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Not all complaints were recorded in the complaints file or being investigated thoroughly to ensure the service were learning from mistakes and striving to continually improve.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not embedded by the Registered Manager to ensure they were effective. The Registered Manager had not investigated all complaints to ensure the service were listening to people.

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not adequate staffing levels to ensure people received care on time and for the duration of their calls.