Haven Social Care 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?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 9 and 16 November 2016 and was announced. The provider was given 48 hours' notice as they provide a domiciliary care service and we needed to be sure people would be available to speak with us.

Haven Social Care Limited provides personal care to adults living in their own homes. At the time of our inspection they were supporting 24 people.

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

The service was last inspected in January and February 2016 when we found breaches of two regulations and made one recommendation. These issues had not been addressed.

Staff were not recruited in a safe way as interviews and skills audits were not assessed by the provider. People told us there were not enough staff and this meant they had to wait for care, particularly at weekends. The provider did not maintain sufficient records to ensure that staff identities were known. Staff did not receive sufficient training or support to perform their roles.

People told us, and records confirmed, care plans were reviewed and updated every six months. Care plans were task focussed and did not contain information about people's preferences for care, food or staffing. There was limited information about people's pasts, cultures and identity. We have made recommendations about recording people's dietary preferences, cultural and identity needs.

People receiving care lived with a range of long term health conditions. The support they required to maintain their health and the impact their health conditions had on their support was not recorded. We have made a recommendation about recording people's health needs.

Risk assessments were in place for some identified risks. However, the measures in place to mitigate risk were not robust and did not contain enough information for staff to use to keep people safe. Some risks had not been properly identified and there were no measures in place to mitigate them.

People were supported to take their medicines. There was insufficient information in care plans to ensure this was managed in a safe way. Records of medicines were unclear and did not show they were administered as prescribed. The service did not check medicines records to ensure medicines were managed safely.

People told us they were offered choices and care workers asked their permission before providing care.

Records of consent were not in line with legislation and guidance as friends and relatives without appropriate legal authority had signed consent forms of people's behalf.

The provider had a complaints policy in place and had not received any formal complaints since our last inspection. Records showed that feedback had not always been responded to. We have made a recommendation about responding to feedback.

Feedback about the management and leadership of the service was mixed. People and some staff told us the registered manager was kind and supportive. Other staff told us the service was disorganised and the registered manager did not respond when they requested support.

There were no effective systems in place to monitor the quality and safety of the service. Records were not routinely checked and some could not be located during the inspection.

People told us staff had a caring attitude and treated them with dignity and respect. Care workers spoke about the people they supported with kindness and affection.

We found breaches of six regulations. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.'

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the 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. There were not enough staff and staff were not recruited in a safe way.

Medicines were not managed in a safe way.

Risks to people were not always identified. The measures in place to address risk were not sufficient.

People told us they felt safe with care workers.

Staff knew how to respond to concerns that people were being abused.

Is the service effective?

Inadequate

The service was not effective. Staff did not receive the training required to perform their roles.

The service was not seeking consent from people in line with legislation and guidance.

Care plans did not contain details of people's dietary needs and preferences. Records did not show that people had been supported to eat and drink enough and maintain a balanced diet.

The service did not support people to access healthcare services. The impact of people's health conditions on their care was not clearly recorded.

Is the service caring?

Requires Improvement

The service was not always caring. Care plans did not contain information regarding people's pasts or interests.

The service did not use information about people's cultural background to inform their care preferences.

The service did not identify if people's sexuality had an effect on their care preferences.

People told us staff had a caring attitude and staff spoke about the people they supported with kindness and affection.

Is the service responsive?

Inadequate

The service was not responsive. Care plans did not include details of people's preferences for how they liked to receive care.

Care plans were task focussed and were not personalised.

People were involved in writing and reviewing their care plans.

The service had a robust complaints policy. However, records showed that feedback was not always responded to.

Is the service well-led?

Inadequate

The service was not well led. Systems and processes were not operating effectively to monitor and evaluate the quality of the service.

There were no management checks on records of care to ensure they were of sufficient quality.

Records were not stored appropriately and could not always be located.

Some people and staff said the manager was kind and effective. Other staff told us the service was disorganised.

Haven Social Care Limited

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 9 and 16 November 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection was completed by two inspectors 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. The expert had experience in caring for someone who used a domiciliary care service.

Before the inspection we reviewed the information we already held about the provider including feedback from people and staff we had received since the last inspection and notifications the provider had submitted to us. We sought feedback from the local authorities who commissioned the service and the local Healthwatch.

During the inspection we spoke with seven people who used the service and two relatives. We spoke with six members of staff including the registered manager and five care workers. We reviewed the care records of six people who used the service including care plans, risk assessments, medicines and care records. We reviewed 13 staff files including recruitment, training and supervision records. We also reviewed policies and other documents relevant to the management of the service.

Inadequate

Is the service safe?

Our findings

At our inspection in January and February 2016 the provider had been in breach of Regulation 18 as there had been insufficient staff employed to meet people's needs. There had also been a breach of Regulation 19 as the provider had not taken sufficient steps to ensure that staff were suitable to work in a care setting. We found the service was still not meeting these regulations.

People and relatives told us staffing levels continued to be a problem, particularly at weekends. One person said, "They definitely don't have enough staff at weekends." Another person said, "At the weekend there is an issue as staff are late." A third person told us, "They could do with a bit more staff, especially at the weekends as they are always a few hours late." A relative told us, "They [staff] have a tendency of being late. It happens two or three times a week. If they had more staff it wouldn't be a problem."

Feedback from staff regarding staffing levels was mixed. Two staff told us they thought that there were enough staff and they did not feel under pressure to take on additional care visits. However, two other staff told us there were issues with staffing levels. One member of staff said, "Lack of staff is an issue, sometimes I have to do double calls on my own because they can't get cover."

The provider used an electronic visit logging system for some people to record the length and time of visits by care workers. The records showed multiple log ins for the same members of staff at the same time. In addition, the records showed that visits regularly happened at different times to those on the schedule. For example, one person's records showed that over five days where calls had been logged they received an average of 13 minutes care per visit when 45 minutes were scheduled. This person received their care earlier than scheduled. Another person's electronic call data showed they had a fifteen minute visit scheduled for 4pm and a 45 minute visit scheduled for 6pm. The call log data showed they regularly received these visits as joint visits from 5pm until 6pm. There was no record that this change had been agreed in their care plan review. This meant people were not always receiving care in line with their agreed plan and feedback from people and staff was that this was because there were not enough staff.

The above is a continued breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's recruitment policy was robust and included a detailed pre-employment skills assessment process, checks on references, and criminal records checks on staff to ensure they were suitable to work in a care setting. Records showed the policy was not being followed. Staff files reviewed did not contain appropriate checks on the identity of staff members. There were no photographs of staff to confirm they were the people whose identities, right to work and criminal histories had been checked. This meant the service was not able to demonstrate the staff visiting people in their homes were the people who had been assessed as suitable to work in care. The registered manager took action after the inspection to ensure staff identities were checked.

Recruitment records showed staff completed skills and values questionnaires before being interviewed for

the post. However, records showed these had not been assessed by the staff completing the recruitment or reviewed by the registered manager. There were discrepancies between staff employment histories on resumes and application forms. There was no record showing this had been discussed with applicants. References supplied were not always from the staff member's most recent employer. Although there was a documented reason for this in one file, this was not the case for other staff. In addition, for one staff file the references were dated on the same date as their assessments and interviews suggesting they had been brought by the candidate to the interview rather than collected by the service after they had assessed the candidate as suitable. This meant the service could not be certain they were genuine references. Another staff member's references had been submitted to the provider via the staff member's email rather than to the registered manager. This is poor practice as it meant there was the opportunity for the staff member to edit their references. The service had not maintained staff files for all the staff who were working with people. The registered manager could not locate any information regarding one staff member who had been employed by the service for over a year.

Records showed the service requested criminal records checks on applicants to ensure they were suitable to work in a care setting. However, records also showed that staff worked before the results of these checks were known. The registered manager told us they completed risk assessments and put measures in place to protect people while staff were awaiting the results of their criminal records checks. Records showed that six staff had worked in people's homes before their criminal records checks had been completed but only one risk assessment was available. This meant the service was not completing recruitment in a way that ensured that staff were suitable to work in care. After the inspection the registered manager took action to retrospectively compile appropriate information regarding staff identity and suitability to work in care. This information was reviewed.

The above is a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff helped them take their medicines. One person said, "They [staff] give me the pack which has the medication in it." Another person said, "They [staff] just give me the box which has the medicine in it and they bring a glass of water." When the service supported people to take their medicines, the information required by staff to do this safely was not clearly recorded in care plans. For example, one care plan listed the medicines to be administered and the times at which they should be taken, but provided no information on the purpose or potential side effects of the medicines. The plan did not contain information about how to support this person to take their medicines, for example, from a medicines pot or a spoon. This person had been prescribed a blood thinning drug. The administration of blood thinning drugs requires specialist training and appropriate records to be in place as the dosage can change frequently depending on the results of blood tests. The staff supporting this person had not received training on the specialist administration of this medicine. The only information available to staff was, "Refer to yellow book at 6pm, variable dose." This was not sufficient information to ensure this person received their medicines safely.

Another person's care plan stated staff should crush their medicines following advice from the hospital. However, there was no information in the care plan relating to how to crush the medicines safely and no record that the service had checked the medicines were suitable to be crushed. The registered manager told us the person's relative administered their medicines. However, this was not clear from the care plan which stated, "Care workers give all medicines." The instructions on the medicines administration record also stated, "Care workers to directly administer medicines from blister pack as supplied from pharmacy." This meant there was a risk that people were not receiving their medicines as prescribed because staff did not have sufficient information available to them.

The service did not routinely collect medicines administration records to check that medicines had been administered as prescribed. The registered manager told us they planned to introduce regular collection of records following our inspection. The records reviewed were unclear, inconsistent and did not show people had taken their medicines as prescribed. One person had two MAR for the same month, one of which had been completed to the end of the month, one of which had been completed until the 25th of the month. The completed record showed four different staff signatures for medicines administered at the same time on the same day. The registered manager told us they had accidentally removed the original MAR when completing a spot check and the care workers had backfilled a new sheet when they could not find the original one. This was poor practice as the MAR is a contemporaneous record and back filling demonstrates staff have not understood the purpose of the record.

Another person's record had been completed with a combination of ticks and signatures. The number of ticks and signatures did not correspond to the amount of medicines prescribed. This meant it was not possible to tell from the records that the person had received their medicines as prescribed. A third set of records showed that no staff member had signed for this person's night time medicine for two months and no staff member had signed for this person's lunch time medicine for another two months. This meant people were at risk as it was not clear they had been supported to take their medicines as prescribed.

Care files contained a range of risk assessments relating to identified risks. However, they did not contain enough information to tell staff how to effectively mitigate risks. For example, one person was identified as being at risk due to moving and handling needs. The person used a hoist and had specific needs relating to supporting their posture. The risk assessment for moving and handling in relation to getting in and out of bed stated, "Independent with help of one staff." The level of risk was coded as six, meaning a major handling hazard and high risk, and there was a comment that the person was, "Prone to fall." There was no information to tell staff what help they provided to this person and no information about how the risk was reduced. Further information in the care plan stated, "Requires two care staff with all transfers." This meant there was conflicting information within the documentation about the level of support this person required.

Another person's care file contained an updated assessment from a hospital which identified the person had swallowing difficulties, was at risk of chocking and chest infections and was under the care of district nurses due to pressure wounds. There were no risk assessments in the file relating to eating and drinking or pressure care. This meant that measures were not in place to mitigate identified risks. A third person's care file included a note that they had broken a bone following a fall. The only risk assessments in this person's file related to managing their medicines, there were no measures in place to reduce the risk of future falls or to support their mobility. This person had diabetes and their one of their medicines is prescribed for the management of seizures and epilepsy. However there was no information for care staff regarding the risks associated with these health conditions. This meant that risks were not appropriately managed.

The above issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe with care staff. One person said, "I trust them [staff]. It's the little things. There has never been anything missing or when they leave she makes sure the doors are locked. Things like that." Another person said, "I have never not felt safe." Two of the staff we spoke with told us they had received training in safeguarding adults. One of them said, "It was about how to safeguard our clients from harm and how to look after them." Staff told us they would inform the registered manager if they had concerns that someone was being abused. The registered manager knew how to escalate safeguarding concerns appropriately. Records showed the service had been involved in one incident that had been considered a safeguarding. The records showed the service had taken appropriate action to protect the person from

avoidable harm and abuse.

Inadequate

Is the service effective?

Our findings

At our last inspection in January and February 2016 we made a recommendation about staff supervision. At this inspection we found this recommendation had not been followed. Care workers who had joined the service since our last inspection had no records of inductions to the service or of individual supervision being provided. One member of staff had joined the service in September 2016 and their file contained no recorded supervisions or induction, however they had been placed on an improvement plan in November 2016. Another member of staff had received positive feedback about their performance in July 2016 but was also placed on an improvement plan in November 2016. There was no indication from the records there had been any attempt to provide these with the support they required to perform their role. Records showed the registered manager had held two group supervisions for care workers. One of these had happened in April 2016 and the other in September 2016. After the inspection the registered manager provided records that some care workers had received one-to-one supervisions.

Staff gave us mixed feedback regarding the training they received to perform their roles. Although two staff told us they received the training they required and spoke highly of the training available, two other staff told us they had received no training since starting work at the service six months previously. Staff files contained certificates of attendance for in-house training in areas including moving and handling, medicines management, dementia awareness, communications, first aid, and end of life care. The files of two coordinators were reviewed. The role of coordinators included completing recruitment of care workers and the completion of care assessments and reviews of care. Records showed that coordinators had not received any training in these areas despite it being a key part of their role. This meant they had not received the training required to perform their roles.

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

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

People told us that staff asked for their consent before delivering care. One person said, "They [staff] always ask you do you want to do this or can I do that?" Another person said, "Things like washing they will ask me if it's OK to do that, can you turn over? Do you want to do your face today or do you want to put cream all over your body or just on your arms? Things like that. They give me the choice." Care plans contained various consent forms, including consent to care and medicines. In five of the six care plans reviewed the consent forms had been signed by a family member or a friend of the person. Although in one of these files it was noted the person had expressed their consent verbally and requested another person sign on their behalf, in

the other cases it was not recorded why another person was providing consent. It is only legal for another person to consent on someone's behalf if they have been appointed by the person under a Lasting Power of Attorney or by the Court of Protection as a deputy. The registered manager confirmed that none of the people who had signed consent forms of people's behalf had the legal authority to do so. This meant the service was not seeking consent in line with legislation and guidance.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed most people received support from family members to ensure their dietary needs were met. Where the service was involved in preparing food and supporting people to eat the details in their care plans were limited. For example, one person's care plan stated, "Prepare breakfast. Support him with feeding while he is seated and upright." There were no details regarding people's dietary preferences, foods people particularly liked or disliked in care plans. The registered manager told us the people who were supported with eating and drinking were able to communicate their choices clearly to care workers. However, this was not recorded in the care plans. Staff completed log sheets where they recorded whether they had supported people with meals. However, these did not include information about what food and how much of it the person ate. This meant the service was not monitoring whether people were supported to eat and drink enough to maintain a balanced diet when this had been identified as a care need.

We recommend the service seeks and follows best practice guidance around recording dietary preferences and intake.

The registered manager told us that meeting people's health needs in terms of supporting people to access healthcare services was not within their remit. They said, "We try not to [support people to access health services]. We will tell social services or the family if we think someone is unwell." Staff told us they reported any concerns they had regarding people's health to the registered manager. A relative told us, "When my relative is ill they will call me and let me know what is happening and then I sort it out."

Records showed people receiving a service had complex health conditions including epilepsy, stroke, heart conditions and physical disabilities. Care plans contained information of people's diagnoses, but did not contain information about what the impact of the diagnosis was on the person and how it affected the care they received. This meant that staff had to rely on people being able to communicate clearly about their health needs. There was a risk that people may not always be able to do this, particularly when they are in poor health.

We recommend the service seeks and follows best practice guidance around recording people's health needs and the impact they can have on support received.

Requires Improvement

Is the service caring?

Our findings

People told us staff had a caring attitude. One person said, "Definitely they [staff] are caring." Another person said, "They [staff] are friendly and talkative." Staff spoke about the people they supported with kindness and affection. Staff told us how they built relationships with people and learned about their lives. One member of staff said, "We started to chat. When [person] is happy she tells us about different things. She likes music and used to be a member of [religious organisation]."

People told us they felt they were treated with dignity and respect by care staff. One person said, "They try their best, things like keeping my door shut when I'm in the toilet or when they are helping me get changed."

Some of the care plans viewed contained a section where people's life histories, significant memories and experiences could be recorded. These had been well completed at the last inspection in January and February 2016. However, as plans had been reviewed and updated since the quality of this information had deteriorated and people's views and preferences were no longer clearly recorded. In two of the plans this section was not completed. For example, in the section about "Major life events" one person's plan stated, "Husband says bringing up the children was memorable." There were no further details that care staff could have used to initiate or develop their relationship with the person.

Care plans also contained a section where details of people's significant relationships could be explored and recorded. Where this had been completed the details were limited and did not contain information that would help built rapport with people. For example, one person's care plan said, "Recalled bringing up her children and was very happy to share a few moments from her past." These moments had not been captured in the plan. This was discussed with care workers who told us they learnt about people's pasts from talking to them while delivering care. One care worker told us they did not think it was valuable to have this information recorded in a care plan. They said, "That information [about former lifestyle and relationships] is not there, no, it wouldn't be useful in a care plan. That's just for what to do on the visit." This showed a task focussed approach to care plans and a lack of understanding about how person centred approaches encompass people's pasts into their current care.

Care plans contained a section relating to people's cultural needs. The registered manager told us that no one had any cultural needs that affected how they wished to receive their care. The sections regarding people's culture contained limited information. For example, one person's plan stated, "[Person] did not express any cultural needs." Another person's plan stated, "From [area in the north of England]. Mentioned that fascinated by [religious tradition]" There was no further information about whether this fascination affected their care preferences.

The registered manager told us the service did not support anyone who identified as lesbian, gay, bisexual or transgender (LGBT). As questions regarding sexuality were not included in the records viewed we asked how the service knew that no one identified as LGBT. The registered manager said, "We know there's none [people who identify as LGBT] but it's not in the assessment." This meant there was a risk that people's

preferences as influenced by their culture and sexuality were not identified and met by the service as they did not ask any questions regarding this.

We recommend the service seeks and follows best practice guidance on identifying and supporting people's needs in relation to their cultural and sexual identity.

Inadequate

Is the service responsive?

Our findings

People told us they had care plans and had been involved in writing and reviewing them. One person said, "Yes I do [have a care plan]. I helped to write it and it has been updated a few times." Another person told us, "We created one together with my daughters. I have a copy of it." A relative said, "We were all there together to do it [write the care plan] and we have meetings to update it as well. People also told us that it was a straightforward process to arrange changes to their care, although two people commented that changes could take a few weeks to take effect. One person said, "I have increased my support from two times a day to three and it was only a problem for the first week, then they [provider] sorted it out." A relative said, "Most of the time there is no problem in getting dates or times changed, but every so often it can take a little while to get through to them and they still send someone at the wrong time. Like when my relative was in hospital I cancelled the call and someone still came round."

Records showed care plans had all been reviewed and updated since our last inspection. This was in line with the provider's policy that care plans should be reviewed every six months. However, the quality of the care plans produced following review had deteriorated since our last inspection in January and February 2016. The reviews and care plans had been completed by staff who were no longer employed by the service.

Care plans viewed were task focussed and contained no information regarding people's preferences for how they wished to receive their care. For example, one person's care plan stated, "Two care workers to support [person] with having a full strip wash in bed, toileting needs, change incontinence pad, cream body, check body pressure areas." Another person's care plan stated, "Two care workers to assist with hoisting to commode, toileting, washing, change pad, cream, dress and put back to bed." There were no details about how people liked to be washed, if they had needs or preferences regarding products used for washing or moisturising their skin. There were no preferences recorded in terms of gender of the care worker. This meant there was a risk that people did not receive care that met their preferences, as their preferences were not recorded.

The provider had developed a template sheet to record what care and support was provided during visits. During the inspection the registered manager collected records for review. The records viewed were incomplete, with one person only having records for six days in July, six days in August, three days in September and four days in October 2016. Other records reviewed were unclear. For example, it was not clear which staff had actually attended visits as they were not signed and some of the sections of the form, for example, regarding food or nature of personal care provided, were not completed. This meant there was a risk that people were not receiving care in line with their needs and preferences as records of care provided were incomplete.

The above is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a robust complaints policy with clear timescales for response. The registered manager informed us they had received no formal complaints since our last inspection. They advised this was

because any issues were dealt with informally. However, records of telephone calls made to people showed that one person had complained about communication with the office, and specifically the communication of the registered manager. There was no record that any action had been taken to resolve these concerns. This meant that complaints were not always dealt with in an effective manner.

We recommend the service seeks and follows best practice guidance on managing complaints.

Inadequate

Is the service well-led?

Our findings

Feedback from people and relatives regarding the registered manager was mixed. One person said, "She's a lovely lady, very caring and helpful." A relative told us, "She is a nice woman. I have spoken to her a few times and she knows what she is doing." However, another person told us, "I don't know who the manager is."

Staff also gave us mixed feedback about the registered manager and their responsiveness to any issues they raised. One member of staff said, "The manager calls us and we can call her with any problems. For me it [the service] feels that everything runs as it should." However, other staff members told us they did not feel the manager was approachable or available to them. One staff member said, "I've never worked somewhere so disorganised and so unprofessional. I've called and texted so many times and nothing ever changes."

At our last inspection in January and February 2016 we made a recommendation that the service seek and follow best practice guidance in relation to monitoring the quality of the service provided. This recommendation had not been followed. Records showed that coordinators carried out spot checks on carers when they completed care reviews. However, there were no checks on care workers outside of this. Records of spot checks were only found in three of the 13 staff files checked. Records showed that coordinators had completed telephone quality assurance monitoring during September and October 2016. There was no record that these calls had been completed between our last inspection in February 2016 and September 2016. This meant there was no consistent work to monitor evaluate or improve the quality of the service.

Care file and staff file templates both included a place where the registered manager could indicate they had reviewed the quality of the plan or recruitment. These had not been completed. This meant there was no record that the registered manager had checked the quality of care plans or recruitment records. Our inspection found that the quality of these records was poor and this had not been identified by the registered manager.

The registered manager was asked how they monitored the quality of the service, including how they knew that care plans had been followed. They told us they planned to collect log sheets on a weekly basis in order to review them. However, this had not been in place and there was no system to monitor that care was being delivered according to the care plan. There was no routine monitoring of medicines administration records which meant the registered manager could not be sure that medicines had been administered as prescribed. The lack of audits by the registered manager meant the issues found on inspection had not been identified or addressed by the service.

Records showed the registered manager held meetings with both office based staff and group supervisions for care workers. Records showed these meetings had been used to discuss record keeping and ways to ensure the registered manager was able to audit records of care and medicines. The last recorded meeting was in September 2016 where it had been agreed the registered manager and coordinators would collect records on a weekly basis. This had not happened by the time we inspected in November 2016. This meant

the measures in place to improve the monitoring of the quality of the service had not been implemented.

The registered manager was asked to supply us with information about the staff employed by the service as part of the inspection. They were unable to locate all the information required. This was particularly the case when information was requested about staff who no longer worked for the service. The registered manager told us they archived old staff files in order to re-use the stationary used to store them. This meant the registered manager was unable to provide information regarding staff who had been employed in the delivery of regulated activities. Records were stored in various locations in the office, including in unlocked archive boxes that any member of staff entering the office could have accessed. This meant there people's personal and confidential information was not stored in a safe way.

During the inspection various concerns and issues were raised with the registered manager. This included concern that untrained staff were administering warfarin. Warfarin is a medicine prescribed to thin the blood and its administration must be carefully managed by trained staff as the dosage can change regularly. The registered manager told us their staff were not administering warfarin. However, the registered manager had known staff were administering warfarin and contacted the care worker to tell them to stop doing this. The registered manager took no action to ensure alternative support was put in place to ensure this person received their medicines. This put the person at risk of not receiving their medicines.

The above is a breach of Regulation 17 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	Regulation 9 HSCA RA Regulations 2014 Person-centred care 9(1)(c)(3)(b) Care plans did not contain information about preferences and care was not designed to meet people's preferences.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent 11(1) The service was not seeking consent from the relevant person in line with legislation and guidance as people without the legal authority to do so had consented to care and treatment.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12(1)(2)(a)(b)(g) Risk assessments were not robust and did not identify or mitigate risks faced by people. Medicines were not managed in a safe way.

The enforcement action we took:

We have imposed conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17(1)(2)(a)(c)(d) The quality monitoring in place was not effective as it did not identify issues with care plans, risk assessments and recruitment records. Staff and service user records had not been appropriately maintained.

The enforcement action we took:

We have imposed conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed 19(2)(a)(3)(a)(b) Recruitment processes had not operated to ensure that staff were suitable to work in a care setting. Records relating to staff employed had not been checked as required.

The enforcement action we took:

We have imposed conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing 18(1)(2)(a) There were not enough staff to meet people's needs. Staff did not receive the training and support required to perform their roles.

The enforcement action we took:

We have imposed conditions on the provider's registration.