Scott Care Limited

Scott Care`s Medway Branch

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Scott Care's Medway Branch provides personal care to older people living in their own homes. At the time of the inspection 180 people were using the service.

People's experience of using this service and what we found
There were not always enough staff to keep people safe and meet their needs. People had not received visits, not always received their full visit or at the time they needed to meet their needs. This meant people had not received essential care and medicines. People and relatives told us they were not always informed if their carer was running late. Medicines were not managed safely as records did not make it clear what medicines were prescribed.

Reporting of incidents and complaints was unreliable and inconsistent. Not all complaints had been investigated and used to make improvements to people's care. Missed visits had been an on-going concern and an action and development plan with new systems to prevent future reoccurrence had been completed. However, systems for managing these risks were ineffective and people had been placed at risk as a result.

The provider had not achieved an open and person-centred culture and had not ensured the delivery of high quality and safe care. Staff gave mixed feedback on the support they received from the manager and communications needed improvement. The provider lacked oversight of staff training and supervision records. People and staff were not engaged with the service. People told us they found it difficult to contact the office and their calls were not returned.

Lessons were not always learnt when things went wrong. Quality assurance systems were not used effectively and had not identified all the concerns we found at inspection. Feedback from surveys and complaints had not always been analysed to identify trends. Learning from these was therefore missed and the provider had failed to make necessary improvements.

People's care was not always person centred and planned to meet their needs. Care plans lacked detail of people's likes and dislikes. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

There was a lack of risk management around people's individual needs. We have made a recommendation about this. Not all allegations of abuse had been reported to the manager and therefore not all had been investigated by the manager. We have made a recommendation about safeguarding policy and procedures. Safe recruitment systems were in place although some improvements were needed with obtaining professional references.

Feedback on whether staff were kind and caring was mixed. We have made a recommendation about

reviewing people's visit lengths and times to ensure people are treated with dignity and respect. People's communication needs were not always met. We have made a recommendation about the provision of accessible information.

Staff had not received training around all individual's needs. We have made a recommendation about staff training. People had not always received consistent staff to meet their needs. Assessments lacked information about people's choices. People did not always have choice and control over their care as they didn't always receive their care at a time to meet their needs.

People's end of life wishes were not always recorded. Therefore, staff did not have the guidance to support people in line with their wishes should an unexpected death occur. We have made a recommendation about the management of 'Do Not Resuscitate' orders.

Environmental risks to people were managed safely and people were protected from the risk of infection. Where staff prepared meals for people or assisted them to eat, they were aware of people's needs in relation to any associated risks. People were referred to appropriate health professionals and staff worked in partnership with other agencies to ensure people's needs were met.

People's needs around equality and diversity were identified. People confirmed staff respected their privacy when providing personal care. People were involved in their care on a day to day basis. New staff received training and an induction to the service.

The provider had regularly sought people's and relative's views on the quality of the care they received. People and relatives told us they could complain if they needed to. The manager clearly understood their role and responsibilities.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 15 August 2019).

Why we inspected
The inspection was prompted in part due to concerns received about the quality of care and missed visits. These concerns included staff not staying for the duration of their visits, not visiting at the right times and therefore not providing the care needed. A decision was made to inspect the service and examine those risks.

We have found evidence that the provider needed to make improvements. Please see all the sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

The provider and manager were responsive to our concerns and has completed an initial action plan following our Inspection feedback. At the time of writing we are unable to confirm whether any action taken has been effective.

Enforcement
We have identified breaches in relation to the following at this inspection: The provider had not ensured there were enough staff to meet people's needs. The provider had not ensured people's medicines were managed safely. The provider had not acted in line with the Mental Capacity Act and had not ensured care was person-centred. The provider had not investigated all complaints and acted in response to failure. The

provider had failed to seek and act on feedback to improve the service. The provider had failed to maintain accurate and complete records. The provider had therefore not ensured effective systems to assess, monitor and improve the safety and quality of the service and ensure it was effectively managed.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Scott Care`s Medway Branch

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by two inspectors and an assistant inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager who was in the process of registering with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we needed to be sure that the provider or manager would be in the office to support the inspection.

Inspection activity started on 20 February 2020 and ended on 28 February 2020. We visited the office location on 20 and 21 February 2020. We spoke with staff on 20 February 2020. We spoke with people and relatives on 24 February 2020 and we spoke with a commissioner on 28 February 2020.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We received feedback from a health care professional. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and five relatives about their experience of the care provided. We spoke with eight members of staff including care co-ordinators, the recruitment and training manager, and care workers. We spoke to the manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including quality surveys, complaints and incident records were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, action plans and quality assurance records. We spoke with one commissioner and one relative. We continued to receive information and notifications about the service and took this into account when we made the judgements in this report.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

● The provider had not ensured there were enough staff to keep people safe and meet their needs. Although rotas showed enough staff were deployed and an electronic system was used to ensure all hours were covered. There had been incidents where people had not received care. This was due to many reasons including; the manager had been unable to arrange cover for staff absence at short notice at weekends. Staff had not been sent rotas that had been updated due to staff absence; staff had not followed their rotas correctly, care co-ordinators had not reallocated calls when staff called in sick. Staff had not informed the manager of their absence and had swapped visits without following correct procedures. Co-Ordinator's did not always allocate correctly to allow enough time.

● The provider had a system in place to monitor for missed and late visits. However, this was not always effective as there had been on-going incidents of missed and late visits. Missed call alerts had not always been checked and actioned. There had been at least 36 missed visits, we could evidence, since the last inspection in July 2019. It was not possible to determine the exact number as these were logged in several different places and records were hard to follow. Following our inspection there have been at least 16 missed calls in less than two weeks. This had led to at least three safeguarding's raised as people had missed essential care and medicines. One person had been left sitting in their wheelchair overnight. We spoke to the persons relative about this and was told this was the third time this had happened, only this time the person did not have their call bell to raise the alarm with them. The provider had to rely on people's families where possible to provide their care. This put people at risk who did not have family nearby to rely on.

● There had been incidents where people did not receive care at the time, they needed to meet their needs. People and relatives raised concerns with the timing of calls. One relative said, "Timing is a challenge. Office scheduling is not always right. The office puts down unsuitable times, especially when they send new carers." Another relative told us how they checked records to make sure staff had turned up. They said, "There was a period where they turned up all over the place. One night they turned up at 22.30."

● People and relatives told us they were not always informed if their carer was running late. One person said, "Yes and No, sometimes they let me know if they will be late. Just depends who is on." One relative said, "The trouble is if they know they are going to be late, they ring the office and sometimes I get a call and sometimes not. The call time is 09.30 and they sometimes don't get here until 11.30, sometimes 12.00." Another relative said, "They don't arrive on time, this is one of the biggest issues. The problem of time is fixed and then the problem starts again." They described how as their loved one needed care with their incontinence. This had impacted on their loved one as they have found them left wet and uncomfortable.

● One staff told us they informed the office if they were running late but that communication was poor, and people were not always told if they were running late. They said, "Some have family there, if they don't it affects them as we may be two hours late."

● There had been incidents where people did not receive their full length of visit. People and relatives told us staff did not always stay for the full length of the call. One relative said, "A half hour call is 20 minutes. They don't all use their phones to log in. They used to ask to use our phone, but they don't do that anymore. I have been looking at times as they log inaccurately."

The provider had not ensured sufficient numbers of staff were deployed to ensure they could meet people's needs. This placed people at risk of harm. This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Safe recruitment systems were in place, and all the appropriate pre-employment checks were completed by the provider to protect people from the employment of unsuitable staff. These included two references, a full employment history and Disclosure and Barring Service (DBS) background checks for all staff. DBS checks help employers to make safer recruitment decisions. Two staff had not received professional references and those from previous employers. We spoke to the manager about this and was told they always try to get professional references first, if not then they obtain personal references.

Using medicines safely

● Medicines were not managed safely. This was because medicine administration records (MARs) only recorded what medicines had been given by staff when they visited. They did not include what medicines had been prescribed and how and when these should be taken. A list of prescribed medicines were recorded on people's assessments, but these had not been kept up to date. Therefore, it was impossible to determine if people received their medicines as prescribed as staff did not have a list of prescribed medicines to sign against. People were therefore at risk of not having their medicines safely as prescribed.

● The manager had identified a lack of medicines auditing and had requested staff to return MARs to the office for auditing. The nominated individual has confirmed this was underway. However, the MARs were not fit for purpose as auditing these would not determine whether people received their medicines safely. We spoke to the manager and nominated individual about this and they have since introduced new MARs.

● There was a risk medicine errors would not always be identified as MARs were not adequately completed. When medicine errors were identified these had been recorded. For example, as staff had provided an evening call too early, they had not been able to give the person their medicines. This was part of the care provided, however, they had only logged they had prompted the person to take their medicines at 9pm. Staff the following morning found the medicines had not been taken. The recorded action had been to contact staff and tell them they cannot do this.

The provider had failed to ensure the proper and safe management of medicines. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● Lessons were not always learnt when things went wrong. For example, missed visits had continued to be an issue in the service despite these incidents being reported. Accidents and incidents were recorded and monitored by the manager. Records were not clear if all appropriate action was taken to prevent a reoccurrence. For example, some forms had no action taken completed and some were completed but lacked detail around the actions taken. Accidents and incidents records were disorganised and mixed up with complaints records.

The provider had not operated effective systems and processes to monitor and improve the safety and quality of the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● People's care records did not have all the guidance needed for staff on how to manage risks to people. People's needs were identified but there was not always adequate accompanying risk management information. For example, risks were not assessed by the likelihood of occurrence and the impact they would have on people to determine the level of risk to the person. Clear measures to reduce the risk were therefore not identified. This meant the provider could not be sure staff knew how to manage risks to people safely.
● Risk assessments were not completed around people's individual needs. For example, for people at risk of falls. One person had been identified as at high risk of falls following a hospital admission but there was no guidance for staff what to do to prevent and reduce this risk. We spoke to the manager and nominated individual about this. They have shared a new risk assessment form which clearly rates the level of risk to people and identifies actions to take. We are unable to confirm if this has been implemented effectively.

We recommend the provider consider current guidance and seeks advise from a reputable source on risk assessment and management.

● Environmental risks to people were identified, assessed and managed safely. Health and safety risk assessments were completed for people's properties, equipment used and fire safety.

Systems and processes to safeguard people from the risk of abuse
● Systems and policies were in place to protect people from abuse and avoidable harm. The provider and manager were aware of local safeguarding policies and procedures and the need to notify CQC of any concerns.
● Staff had not followed the providers procedures for reporting abuse. Staff were aware of the signs of abuse and told us they knew who to inform if they witnessed or had an allegation of abuse reported to them. However, the manager had not been informed of at least two allegations of abuse. Therefore, these had not been logged and investigated by the manager. This meant the provider could not always be sure that people were protected from the risk of abuse, and action taken to prevent a reoccurrence. The manager has responded to our concerns by opening investigations into these incidents.

We recommend the provider seeks advice from a reputable source to review their safeguarding reporting policies and procedures.

Preventing and controlling infection
● Personal protective equipment (PPE) was made available for all staff to use to help prevent infection. Staff collected this from the office whenever they needed it. There was handwashing guidance in staff toilets.
● Staff had been sent information about the recent concerns of Coronavirus.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement: This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.
● No-one was being deprived of their liberty. However, people did not have mental capacity assessments and associated best interest decisions completed where it was identified they did not have the capacity to consent to their care. This meant the provider had not acted in line with the MCA. We spoke to the provider about this and they had not understood their responsibilities for this legislation. Since the inspection they have identified the paperwork they will use to support this.
● People's care records included if they had a Lasting Power of Attorney (LPA) in place. An LPA is a legal document that lets the person appoint one or more people (known as 'attorneys') to help them make decisions. The registered manager had not verified these by checking the paperwork for this. This meant they could not be sure relatives had the legal right to make decisions and consent on their loved one's behalf. We spoke to the manager about checking with the office of the public guardian where they had been told an LPA is held but had no evidence of this.

The provider had failed to ensure they acted in line with the MCA. This was a breach of Regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us people were asked to consent to their day to day care and needs assessments had been signed. One relative said, "They (staff) always ask my (loved one) if they are ready or not. They (loved one) will say no if not required. One person told us, "They do ask before they do things."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff

working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People's needs were assessed when they were referred to the service. However, care plans did not have all the guidance staff needed to support people in line with their healthcare needs and with best practice. For example, staff cared for one person living with diabetes with a history of related hospital admissions for this. Their care plan identified staff needed to prompt a blood sugar check. However, there was no information about what their blood sugar level should be and what to do if their blood sugar level was too high. There was no information in one person's care plans how to support them living with dementia. There was no information in another person's care plan how to support them living with epilepsy. We spoke to the manager about this and they have identified new documentation to use. We are unable to confirm if this has been implemented effectively.

● Feedback from people and relatives was mixed. One relative told us they were not happy with the care their loved one received, and they were looking for another care provider. Another relative wasn't happy with the standards of personal care. One person told us they are not aware of a needs or care plan. Another person said, "They do look after me. If things are not right, they may call the district nurse in."

● People had not always received consistent staff to meet their needs. For example, one relative told us how their loved one would not answer the door to staff they didn't know, and the office know this, but they don't always send someone familiar due to staff shortages or sickness. They said, "I always say give me a call and cancel but they don't do this."

The provider had failed to ensure the care and treatment of people met their needs and preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's protected characteristics under the Equality Act 2010 were identified as part of their need's assessments. This included people's needs in relation to their culture, religion and gender identity.

● People were referred to appropriate health professionals as required. For example, GPs, and occupational therapists (OT). One person had detailed guidelines in place from their OT on how to use equipment for transferring the person to and from their bed. People's oral healthcare needs were assessed and identified any support needed.

Staff support: induction, training, skills and experience

● All the mandatory training was in place for staff. However, it was impossible to determine how many staff were up to date with their refresher training. This was monitored by the manager and provider but there was no overview. Some staff were overdue training in medicines, adult abuse, fire safety, first aid, food hygiene, health and safety, infection control and manual handling since 2018. Staff had not received training around individual's need such as diabetes and dementia. We spoke to the nominated individual and manager about this and they have started to compile new training records. The provider has identified there are gaps in their training and have included this within their action plans.

● Relatives told us they didn't think staff had enough training. Comments included, "They bring them off the road and put them out. They put a new carer with old staff and then the old staff is gone and left to new staff. No-one comes to check what the girls are doing"; "No, I don't think they have any training." And, "I think the regular ones are experienced but I'm not sure of the newer ones. Comments from people were, "Yes they know what they are doing." And, "Yes the girls look after me all right, if something not right I usually tell them."

● Staff opinion on whether there was enough training was mixed. One staff said, "I learnt a lot from the training. We went through health and safety, filled out questionnaires, watched videos on case studies. We were shown how to use a hoist, catheters and slings. I would go to the training manager if I had any

concerns." Another staff said, "I feel like I had enough training, but the new girls don't have enough training. Some girls don't know how to change a pad or use the hoist." The training manager told us staff had interactive and reflective training on their induction and they made sure that new staff go out with an experienced carer.

We recommend the provider seeks advice and guidance from a reputable source to review their staff training needs in line with the service requirements.

● Staff told us they received supervision. One staff said, "Supervisions do help, to know how you are progressing, if there is something you need to or want to learn." The training manager told us they completed spot checks and medication awareness checks to ensure staff's competence.
● Staff received an induction to the service which included training, such as medicines, safeguarding and moving and handling. All staff were required to complete the Care Certificate. This is a nationally recognised training program to ensure that new care staff know how to care for people in the right way. New staff shadowed experienced staff before providing care.

Supporting people to eat and drink enough to maintain a balanced diet
● Where required staff would prepare meals for people or assist them to eat. Staff were aware of people's needs in relation to risks associated with eating and drinking. For example, one person had been identified at risk of weight loss. Therefore, the manager had contacted a dietician and care plans included the need to leave snacks and drinks to hand. People's care plans included when people needed encouragement to drink enough, for example to prevent urine infections. One relative told us that carers leave drinks and water for their loved one.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

● Feedback on whether staff were kind and caring with people was mixed. One person when asked how staff showed they were caring, told us, "They don't, they are in and out and go. They do what they need to do." Staff did not always have the time they needed to spend time chatting with people. People and relatives told us staff were rushed. One relative said, "They don't do more than what they need to do and go." Another relative said, "Once they know (loved one) they are good and take time to chat with (loved one)." Two staff told us they are sometimes rushed. One said, "Sometimes I wish we could give them more than they have actually got." Another told us how they were trying to get a call extended as staff were rushed to meet the person's needs.

The provider had failed to ensure the care and treatment of people met their needs and preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Comments from relatives included, "They (staff) are gentle with (loved one). They jolly along and tell her what they are doing"; "The girls in the evening are very caring, some won't leave until (loved one) is comfortable."

● Staff respected people's rights to equality and diversity. For example, we discussed with staff how they would support people with their sexuality or gender identity. Staff told us they would be non-judgemental and would respect people's rights to their privacy around this. We spoke to the manager about how they promoted and respected people's equality rights around culture and religion. The manager told us how one person who goes to church calls them when they are planning to go so, they can arrange an earlier visit.

Respecting and promoting people's privacy, dignity and independence

● Staff respected people's privacy and told us how they upheld their dignity when providing personal care. One person said, "Yes, they are cautious with my modesty. Another person said, "Yes, they keep me covered and look after my dignity." However, people were not always treated with dignity as care was not always provided at the right times to ensure this.

We recommend the provider reviews the length and times of people's visits and scheduling processes with regards to their views and impact on how they are treated. We recommend this includes reviewing staff's views around the time they have to provide care which is respectful and compassionate.

● Staff understood the need to promote people's independence. One staff said, "If a person can do

something themselves, they should do that unless they are physically unable to. If they are struggling, I will help them."

Supporting people to express their views and be involved in making decisions about their care

● People were asked their preference of carer gender. However, this had not always been respected as one relative told us how they complained as their loved one was sent a male carer and they had made it clear from the beginning male carers were not acceptable for their loved one. The manager had taken appropriate action to rectify this.

● People were involved in the care they received on a day to day basis by the carers supporting them. Staff told us how they asked people what they needed. One staff described how they promoted choice for people. They said, "I would never pick things for them, they always have choice. I would say, would you like to wear this or that?"

● The provider and manager had regularly sought people's and relative's views on the quality of the care they received through a telephone questionnaire. This considered how satisfied they were overall and asked specific questions around their visits.

● No-one was using advocacy services at the time of our inspection. However, the manager informed us they would support people to access advocacy services if needed. Advocacy services offer trained professionals who support, enable and empower people to speak up.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People's care was not always person centred and planned to meet their needs. Care plans lacked detail of people's likes and dislikes. This meant staff did not always have the guidance and information they needed to care for people in a person-centred way. Feedback we received from people and relatives did not always describe person centred care. Some staff who had been supporting people for some time knew people's needs well. Newer staff did not have the information they needed to ensure this. We spoke to the manager about this. They had identified the need for care plans to be more person centred and had arranged training for staff from the local authority quality team.

● Assessments were focused on people's care needs and held little information about people's choices. For example, on how people liked to be cared for and what their preferences were. People did not always have choice and control over their care as they didn't always receive their care at a time to meet their needs. For example, one relative told us how carers arrived at 8.55 for breakfast and then 11.20 for lunch.

● People's care was not always reviewed to ensure people's needs and preferences continued to be met. We were told people's care plans were reviewed annually but this was not evidenced in people's care records. For one person their review was more than a year overdue. We spoke to the manager about this who told us they were yet to audit people's care records.

The provider had failed to ensure the care and treatment of people met their needs and preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● Complaints had not always been analysed and used to make improvements to people's care. Concerns and complaints where known were logged by the manager. There had been at least six complaints about the quality of the service since the last inspection. The manager had analysed these monthly to consider the number and type of complaint and action taken. However not all complaints had been investigated fully and complaint investigations did not always record outcomes. We discussed one complaint with the manager as not all elements to it had been investigated and there had been no conclusions made. One complaint that had also been raised with CQC hadn't been logged at all and the manager was unaware of it. The staff who received the complaint had not informed the manager of it. We spoke to the manager about this and they have identified actions to rectify this.

● People and relatives told us they could complain if they needed to. One relative told us they have raised several concerns around the care their loved one received, and they haven't been resolved. This was related to the timing of calls not meeting the person's needs and not getting a response from the manager in

relation to messages left at the office. One person told us they had not raised any complaints. They said, "I tell the girls what I am unhappy about and they sort it. I don't need to tell the office." Another person said they have raised a complaint and it was sorted out.

The provider had failed to ensure all complaints were investigated and action taken in response to failure identified. This was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● People's communication needs whilst understood by staff were not always well met. One person with dementia spoke in their native language. They had been supported by Scott Care's for over two years and had relied on communicating through the person's family. However, they had not provided information to the person in a way they could understand. The manager told us they had identified this concern and had planned to work with their family to implement some cards with stock phrases to assist communication with the person.

We recommend the provider consider current guidance on providing accessible information to people.

End of life care and support
● The service was supporting one person at the end of their life at the time of the inspection. There was no end of life plan in place. We spoke to the manager about this and they have completed and evidenced this following our inspection.
● People's wishes and arrangements for the end of their life were not always recorded in their care plans. Therefore, staff did not have the guidance they needed to support people in line with their wishes should an unexpected death occur.
● Where people had chosen, they had a Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) order. This helps to ensure a person's death is dignified and peaceful. Whilst care files identified if people had a DNACPR, copies were not always held to evidence these have been completed in line with legislation.

We recommend the provider reviews their policies and procedures to ensure the information they hold on people's DNACPR's is up to date and valid.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Reporting of incidents and complaints was unreliable and inconsistent. Complaints, concerns, missed visits and incident logs were disorganised and did not match up with the information held. Systems for managing these risks were ineffective. For example, it was impossible to get a full picture of all the missed visits, the reasons for these and what action was taken. Missed visits had been an on-going concern since the last inspection and commissioners had met with the provider regarding this. This had led to an action and development plan with new systems to prevent future reoccurrence. However, the provider had continued to fail to manage this concern and people had been placed at risk as a result.
- The governance framework had not ensured the delivery of high quality and safe care. Not all risks to people had been identified and managed to mitigate the risks. Care records were not complete and up to date to guide staff on the care people needed. Care records were not well organised in the office and individuals care files were hard to locate within the filing cabinets. People's care files had information belonging to other people as these had been mixed up. We spoke to the manager about this and they started reorganising their filing systems during the inspection.
- There was a lack of oversight of staff training to ensure staff had completed the mandatory training required. We did not see evidence of the providers oversight of staff supervision. This had been raised as a concern by the local authority in October 2019. We spoke with the manager and nominated individual about all the concerns we found. They were responsive to our feedback and have put an action plan in place immediately to address the required improvements. We are unable to confirm if these actions have been taken or whether they have or will effectively improve the service.
- Quality assurance systems, such as audits and checks were not completed or used effectively. For instance, these had not identified all the concerns we found at inspection. An action plan completed following a local authority visit in October 2019 had identified the need to complete audits for medicines, daily logs, service user files, staff files, infection control and health and safety by 15 November 2019 and these had not all been completed.
- Feedback from quality surveys, complaints and concerns had not been analysed to identify any trends. The manager had informed people of action they had taken from an annual quality review they did and had responded to individual concerns where these were known. However, the provider had not looked at the bigger picture. Learning from these was therefore missed and the provider had failed to make necessary improvements to the service.
- Managers are required to notify CQC about events and incidents such as abuse, serious injuries and

deaths. The manager understood their role and responsibilities and had met their regulatory requirements whenever they were aware of such incidents. However, they had not informed CQC of a recent allegation of abuse in a timely manner. We spoke to the manager about this and they rectified this the same day. The providers ratings were clearly displayed in the office.

The provider had not operated effective systems and processes to assess, monitor and improve the safety and quality of the service and ensure it was effectively managed. The provider had not maintained accurate, complete and contemporaneous records of people's care. This placed people at risk of harm. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Engagement with people was minimal. There was little evidence that people and those important to them were engaged with the service other than responses to quality surveys. People we spoke to told us they found it difficult to contact the office, that they don't have their messages passed on and their calls returned. Only one relative from the people and relatives we spoke with told us they knew who the manager was.

● Not all staff were engaged with the service and we were told communication has been poor. The manager had put new systems in place to improve this such as newsflashes and we saw evidence of these. The manager told us team meetings were held to share information, but we did not see any evidence of these. The manager told us they plan to start staff surveys and shared the paperwork for this.

The provider had not sought and acted on feedback from relevant persons to continually evaluate and improve services. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager and nominated individual told us how they kept in touch with best practice guidance through signing up to news bulletins from leading health and social care organisations such as Skills for Care and NICE. However, we did not have any examples of how this was put into practice.

● The staff team worked in partnership with other agencies to ensure people's needs were met in a timely way. For example, people's district nurses and occupational therapists.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The provider had not achieved an open and person-centred culture to ensure high-quality care for people. The manager was working on promoting an open culture following a high level of staff changes since they started in October 2019. However there had been complaints and allegations of abuse which had not been reported to the manager. There had been high levels of staff turnover and sickness which had led to people not receiving care.

● Staff gave mixed feedback on the support they received from the manager and provider. Staff told us they didn't feel supported at weekends and that communication with the on-call duty was poor. One staff said about the manager, "They are brilliant, lovely to talk to, understanding, I feel able to talk to them if I have any concerns or worries." Another staff was unhappy in their role and felt they couldn't talk to the manager at all. Another staff described the management team as 'sometimes understanding and approachable'. Whilst another staff said, "(Name of manager) has been on their own, they have done their absolute best. (Name) has done an admirable job on their own. There is only so much they can do without the staff around them."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The manager understood their responsibilities in respect of the duty of candour and had informed the relevant people of any incidents or accidents they were aware of. In these instances, people were given a letter of apology when things went wrong.

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 The provider had failed to ensure the care and treatment of people met their needs and preferences. Regulation 9 1(b)(c) 3(a)(b)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure they acted in line with the MCA. Regulation 11 (1) (3)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the proper and safe management of medicines. Regulation 12 (1) (2)(g)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to ensure all complaints were investigated and action taken in response to failure identified. Regulation 16 (1)

Regulated activity	Regulation

Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not operated effective systems and processes to assess, monitor and improve the safety and quality of the service and ensure it was effectively managed. Regulation 17 (1) (2)(a)(b)(c)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured sufficient numbers of staff to ensure they could meet people's needs. Regulation 18 (1)