RA Care Services Limited

RA Care Services Limited

Inspection report

7 Hessel Street
London
E1 2LR

Tel: 07969559041
Website: www.racareservices.co.uk

Date of inspection visit:
12 October 2016
14 October 2016

Date of publication:
12 January 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected RA Care Services Limited on 12 and 14 October 2016, the inspection was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

At the last inspection on 6 January 2016 we asked the provider to take action to make improvements in relation to safe care and treatment, consent, person-centred care, complaints and good governance. The service was placed into Special Measures as a result. The provider sent us an action plan to tell us what they were going to do to make improvements, however during this inspection we found that insufficient improvements had been made.

RA Care Services Limited is registered to provide support to adults living in their own homes with personal care. At the time of the inspection the service was providing care to 38 people.

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

Medicine records did not provide a clear and accurate record of the medicines staff had administered to people to ensure that they received their medicines safely. Not all staff had completed training in medicines, there was no evidence staff's competency to administer medicines was assessed and no audits were completed on medicine administration records. An audit sent to us after the inspection did not adequately identify concerns about record keeping in relation to medicines.

Risks to people's health and wellbeing were not identified and managed safely by staff. Systems in place to monitor accidents and incidents were not being followed or managed to reduce the risk of further occurrences.

People using the service and their relatives said staff did not miss their calls and the regular staff turned up on time. However, some relatives told us that staff left early and said the care provided was carried out in a hurried way. The provider told us that care workers provided care to a regular group of people and as a result staff rotas were not needed. However, we could not be assured that staff arrived on time as the records we looked at were inconsistent.

Recruitment processes were incomplete and some recruitment checks had not been verified to confirm their authenticity. Therefore we could not be assured that the provider's recruitment processes protected people from staff unsuitable to work with them. Quality monitoring systems were ineffective and did not identify or address shortfalls in the operation of the service. Shortfalls identified at our last inspection had not been satisfactorily addressed by the management team.

The provision of ongoing supervision and performance management for staff was not consistent. Staff told us they received training. However, we found that some of the training they had received was not effective. There were no systems in place to ensure that staff had the skills and knowledge to support people safely and effectively.

We saw evidence that mental capacity assessments had been completed so that decisions could be made in a person's best interests when they didn't have the capacity to make a particular decision for themselves. However, where family members had signed to consent to the care and support of their family member, the provider was unable to demonstrate that the relative had the legal authority to do so and was therefore not working in line with the Mental Capacity Act 2005
Relatives told us that their family members were not always treated with dignity and respect. People were happy with the choice and quality of food. Some people and their relatives told us staff were caring and happy and did what they thought they should to support them. People's preferences had been sought and staff also offered people choices, for example with their nutritional needs. Health and social care professionals were involved in people's care.

Care planning did not always give staff sufficient guidance about how to safely and consistently support people; records were completed incorrectly and it was evident some people's needs were not being met. When we reviewed care plans and people's daily records we found inconsistencies and we were not always able to ascertain the exact care and support someone needed from the records. Care plans were not always reviewed to reflect people's changing needs. People's daily care records and timesheets were inaccurate; this meant that people were at risk of receiving inconsistent care.

We found breaches of regulations in relation to safe care and treatment, fit and proper persons employed, consent, staffing, person centred care and good governance. 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 therefore remains in 'special measures'.

The service was kept under review and we have found that not enough improvement was made. Therefore we are now considering what action we will take in line with our enforcement procedures to begin the process of preventing the provider from operating this service.

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 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.

The provider had failed to make significant improvements to address the shortfalls identified at our previous inspection.

Staff knew how to protect people from abuse and safeguarding concerns were reported as required. However, the provider did not always follow action plans resulting from safeguarding investigations.

Risk assessments were insufficiently detailed to show how people's health care needs were to be safely managed by staff. Accidents and incidents had not been thoroughly investigated.

People and their relatives told us there were sufficient numbers of staff
to meet people's needs. However, safe recruitment processes were not followed and checks were incomplete.

Medicines were not always managed safely. Staff had not received regular competency training.

Is the service effective?

Requires Improvement

Aspects of the service were not always effective.

The provider had failed to make significant improvements to address the shortfalls identified at our previous inspection.

Requirements of the Mental Capacity Act 2005 were not always met or fully understood.

Staff did not receive ongoing supervision to ensure they were adequately supported in their roles. Staff told us they were suitably trained to support people; however we could not be assured that staff competency was appropriately assessed.

People were supported appropriately with their nutritional needs.

Health and social care professionals had been involved in

reviewing people' needs.

Is the service caring?

Requires Improvement

Aspects of the service were not always caring.

Care was not always carried out in a dignified and respectful way.

People's individual preferences and wishes were recorded, and some relatives told us staff were caring and happy with the support they provided.

Support was provided by regular and consistent staff that enabled positive relationships to be established with people.

Is the service responsive?

Inadequate

The service was not responsive.

The provider had failed to make significant improvements to address the shortfalls identified at our previous inspection.

There were inconsistencies in the content of peoples care plans; risk assessments; timesheets and daily records. Care plans were not reviewed to sufficiently reflect people's changing needs. These key documents did not adequately guide staff on people's current care and support needs and how to meet them. People's daily records were not correct and we could not be assured that people's needs were fully met.

Care plans covered people's aspirations; interests and communication needs.

Relatives told us they knew how to raise a complaint and felt confident their concerns would be actioned. However two relatives had concerns but did not raise a complaint.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had failed to make significant improvements to address the shortfalls identified at our previous inspection.

There had been a lack of scrutiny and effective quality monitoring of the service. There was no evidence of a robust system of governance. This resulted in shortfalls not being identified or addressed.

Management did not use their quality assurance system as a means of developing and improving the quality of service.

The provider did seek feedback from people using the service and their relatives, however, there was no evidence to demonstrate how this feedback was used to improve the service.

RA Care Services 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, and to check that improvements to meet legal requirements planned by the provider after our inspection on 6 January 2016 had been made. We looked at the overall quality of the service to provide a new rating for the service under the Care Act 2014; prior to this inspection, the rating for the service was Inadequate.

We conducted an announced inspection of RA Care Services Limited on 12 and 14 October 2016. We gave the provider 48 hours' notice of the inspection because the manager is sometimes out of the office supporting staff or visiting people in their homes. We needed to be sure that the key people were available to speak to. The inspection was carried out by one inspector.

Prior to the inspection we checked information that the Care Quality Commission (CQC) held about the service which included a Provider Information Return (PIR), the previous inspection report and notifications sent to CQC by the provider before the inspection. The PIR is a form that asks the provider to give some key information about the service, including what the service does well and any improvements they plan to make. The notifications provide us with information about changes to the service and any significant concerns reported by the provider.

We considered information of concern which a local authority had shared with us. In addition to this we contacted Healthwatch who told us they had no information of concern. Healthwatch are a consumer group that gathers and represents the views of the public about health and social care. Furthermore, we reviewed the action plan and progress updates sent by the provider following the last inspection.

During our visit we spent time looking at six people's care plans, we also looked at six records relating to staff recruitment and training, and various documents relating to the provider's quality assurance systems. We spoke with the care supervisor, care coordinator, the administrator and the registered manager. Following the inspection we spoke with one senior care worker and 10 care workers, three people who used the service and six relatives of people who used the service on the telephone.

Inadequate

Is the service safe?

Our findings

At our last comprehensive inspection of the service on 6 January 2016, we found that people's safety was comprised in a number of areas. During this inspection we found that the provider had not taken sufficient action to address the concerns and had not made sufficient improvements to ensure people's safety.

Our previous inspection identified that the provider had failed to manage risks to people's health and wellbeing. For example, medicines were not managed safely, risk assessments did not adequately mitigate risks and were not reviewed and updated to reflect people's changing needs. At this inspection we found that some work had been undertaken to address the shortfalls identified, however, people were still not always protected from avoidable harm.

Risk assessments relating to people's health care needs were not always reviewed to ensure people received safe care. We saw that risk assessments included identified risks such as mobility, the environment and health. There was a procedure to identify risks associated with people's care; however risks assessments did not always accurately identify how to manage these risks and were not always updated when people's needs changed. For example, one person had been assessed as being at a high risk from falls and a healthcare professional had identified that the person should wear a pendant that would allow them to call for help if they had a fall.. The person's records showed that they had experienced three falls over a three month period. The daily records showed that the local authority had been informed, however the risk assessment had not been reviewed or updated to reflect these incidents and made no reference to the pendant. Dates on the risk assessment were inaccurate which was acknowledged by the registered manager so it was difficult to assess when the risk assessment was due to be reviewed. The registered manager told us that he knew the person wore a pendant because the relative had informed him, however this had not been included in the guidance for staff to help protect the person from harm. Furthermore, we saw that incident and accident records were incomplete in relation to this person's falls where injuries were sustained and no action had been taken to help prevent further occurrences. There had been no changes to this person's risk assessment or care plan after the accidents had occurred. This meant that we could not be assured that care and support was provided in a way that protected people from avoidable harm.

Three people's care plans recorded risks associated with their health conditions but did not state how care workers should manage these risks and did not include what action care workers should take if the person's condition deteriorated. For example, one person had a pressure sore; this was managed by the district nurse. However, there was no written guidance for care workers to follow when carrying out personal care to ensure that they protected the person's skin and the risk assessment made no reference to the support they needed with their pressure area care. Another person had diabetes and there was no clear information about signs to observe for that would indicate that the person's blood sugar levels could be too low or high and what to do in the event of the person becoming unwell due to unstable blood sugars.

Another person's risk assessment recorded that the risks were high in relation to behaviour that challenged. There was no direction for care workers about how to support the person and manage this risk. We spoke to the registered manager regarding these issues who updated these plans during the inspection; however

people using the service were not involved in these updates.

The above three paragraphs demonstrate a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found a number of concerns regarding people's medicines. For example, we found that medicine administration records (MARs) were not fully completed as they did not include the dose of the medicine; the type of medicines such as tablet or creams or if they had followed specific instructions, for example, to be given with food. In the daily care records for one person one care worker recorded they had 'prompted' a person to take their medicines in the care logs and another care worker had written the word ' administered' during the same morning call. One person required support with a nebuliser, we looked at the care plan and risk assessments and saw that the registered manager had reviewed this on 29 September 2016 and noted errors in the documents and added hand written notes about updates required. However, there were no guidelines written in the care plan about the nebuliser and how this should be managed. Guidelines should include details such as how the person requires assistance, what the risks are and what to do in case the nebuliser does not have its intended benefit of relieving symptoms. The registered manager told us care workers were trained to use this, however when we spoke to the relative they told us they had showed care workers how this was used. The registered manager agreed that this needed to be updated.

Another relative told us that an 'as required' cream was not being appropriately applied to their family member's skin. A third relative had identified errors in their family member's care plan and risk assessment and reported their concerns to the provider in October 2016. This included errors in relation to the medicines to be administered. Therefore we could not be assured that people were receiving their medicines safely as the provider was not operating in line with accepted guidelines regarding medicines recording in a domiciliary care service. The Royal Pharmaceutical Society guidance, 'The Handling of Medicines in Social Care' states that, 'When care is provided in the person's own home, the care provider must accurately record the medicines that care staff have prompted the person to take, as well as the medicines care staff have given.'

We asked staff about their medicines training. Each of the staff we spoke with told us they had completed face to face medicines training with the provider, however one of the care workers we spoke with said they had not received medicines training. There were training records held on file for care workers to demonstrate they had received medicines training as part of their induction; however, there was no written evaluation of the care workers competency to demonstrate they were sufficiently trained with supporting people with their medicines. The registered manager told us these documents were held with the trainer. Therefore was unable to provide any supporting evidence to demonstrate that the effectiveness of medicines training was adequate to ensure care workers had the knowledge and skills to administer people's medicines safely. During the inspection the registered manager told us that audits of medicines management had not taken place. After the inspection the provider sent us a staff medicines competency record and a medicines audit for one care worker.. They also sent us an updated audit including medicines but this did not identify the errors we found, furthermore the audit only identified if people took their own medicines or if staff administered the medicines.

The above three paragraphs demonstrate a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection on 6 January 2016 we found that the provider was not carrying out sufficient checks to ensure that new staff were suitable to work with people using the service. During this inspection we still had concerns about the provider's staff recruitment practices. For example, references were not always fully

completed and did not always included and confirm employment dates. In addition to this, references had not been verified in four of the files we looked at to check their authenticity before staff were employed. We also found discrepancies in application forms, for example in one, dates the care worker had lived at their current address were not recorded, and in four other files previous employment dates were not fully completed to so it was not possible for the provider to explore any gaps in employment.

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

We found that the provider reported safeguarding concerns as required so that they could be appropriately investigated. However the provider was not always following action plans resulting from safeguarding investigations to help mitigate against further incidents.

Staff we spoke with showed they could recognise signs of abuse and would take action by taking steps to ensure the person was kept safe and reporting their concerns to the registered manager. Within the staff files we found that forms signed by staff to confirm they had read and understood the safeguarding policy and procedure. We asked staff about the whistleblowing procedure and told us they were aware of this and knew who to report concerns to. Relatives and the people using the service we spoke with told us there were sufficient staff to carry out their care calls and staff told us they had enough time to travel between care visits.

Requires Improvement

Is the service effective?

Our findings

At our last comprehensive inspection of RA Care services Limited on 6 January 2016 we found that the provider had failed to follow the legal requirements of the Mental Capacity Act 2005 (MCA). This meant that people's rights may not have been protected. Capacity assessments were not undertaken and best interests decisions were not appropriately being made where there were concerns about people's ability to make specific decisions about their care. Staff had limited knowledge of the Act and how to apply it. During this inspection we found that the provider was still not meeting the requirements of the Act.

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. In order to support people to make decisions, staff need to establish whether the person has capacity to make decisions and identify when decisions need to be made on behalf of the person and in their best interests.

We looked at the care plans of five people including two who were living with a diagnosis of dementia. Where appropriate, the provider had recorded where they had assessed people's capacity to consent to their care, and records showed that they had had discussions with family members and other professionals to demonstrate they were working in the person's best interests. However, we found the capacity assessment for one person with dementia carried out in October 2016 recorded that the relative managed all the finances for the person; the next question asked if the relative had Lasting Power of Attorney (LPA) and this was recorded as 'no'. There were no LPA documents in the person's file. In the second file we looked at it was recorded the person had dementia and the relative managed the person affairs, however the capacity assessment recorded there was no one to sign on the person's behalf and there was no LPA found in the person's file. The third capacity assessment we looked a noted that the person had an LPA, however there was no evidence to demonstrate this. Furthermore, the consent form was dated before the care package commenced, the registered manager said this was an error. The fourth assessment was signed by the relative, however the care for the person had commenced in March 2016 and the consent was signed by the relative in July 2016. In all of these cases the registered manager acknowledged these areas and that there was no evidence of who had LPA on files.

We spoke to a relative regarding the consent forms, and they informed us that they had refused to sign this as the form described them relinquishing all their rights to the provider which they were not prepared to do. This meant the families obligations regarding consent to care was not clearly discussed or fully understood by the provider.

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

We asked staff about their understanding of the MCA and they were able to explain this was about people's

ability to make decisions. One staff member said, "It's about giving people choices. I ask them what they would like."

At our previous inspection we found that appraisal forms contained no information regarding care workers ongoing professional development. Following our inspection, the provider told us they would implement the care certificate for all new care workers by the end of April 2016 and said staff would be required to complete an annual assessment and refresher training.

At this inspection, we found that some work had been undertaken to partially address this, however, we identified further shortfalls.

Supervision and appraisals of staff performance were inconsistent and not clearly recorded. The staff we spoke with told us they had received supervision and were supported by the registered manager and we saw that one to one supervisions and annual appraisals were carried out. However, we were made aware of agreed disciplinary action for one care worker following a safeguarding incident. This included additional training and supervision. We viewed the appraisal carried out by the registered manager for the care worker and found this did not identify learning objectives, such as further training, and the care worker had written they had nothing to learn, furthermore there was no written record of the disciplinary action or details to show that any discussions with the registered manager had taken place. The supervision records for another care worker were incomplete and did not contain detail to show that the discussion that had taken place with the registered manager or actions recorded from the last meeting, this was signed by the registered manager and the care worker.

On the first day of our inspection we asked the registered manager if care workers had training in supporting people with specific health conditions such as epilepsy and diabetes. He told us he had trained them but was unable to demonstrate that he was appropriately qualified to do this. On the second day of our inspection he told us he did not train care workers in these areas of care and showed us the training records to demonstrate that care workers had received this training. The registered manager was also unable to provide evidence to show that care workers competency had been assessed following training to ensure it had been effective. The registered manager told us these were held by trainer. Training records did not clearly show when care workers had completed their training, therefore we could not be assured that staff had up to date knowledge and skills in these areas, based on current good practice.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulation 2014.

After the inspection the registered manager sent us a completed appraisal conducted with the worker on 17 October 2016.

The registered manager told us staff received one week classroom based induction training, the opportunity to shadow other care workers and face to face classroom based training with an external trainer. He showed us the course material that was used. This covered a range of topics that the provider considered were mandatory to suit people's needs including, moving and handling, medicines, health and safety, first aid and nutrition. We did not see certificates to show that staff had received training in the Care Certificate, but the registered manager told us they were in the process of completing this. Staff had completed national vocational training in health and social care and the majority of staff had attained these qualifications at different levels.

People's care plans included details of involvement with health and social care professionals. We saw

records that showed referrals were made for additional support when people's health deteriorated. For example, records showed that a care worker had raised concerns about one person's health. We saw records that showed contact had been made with the local authorities to increase the support to ensure the person was safe when receiving personal care. One relative told us that the care worker was shown by the nurse during their care call how to appropriately support their family member with their health needs.

Some people received support from the service to maintain their nutritional needs. When their care commenced the arrangements to provide people with a diet that met their nutritional requirements were assessed. This meant some people received meals from a family carer whilst others were independent following assistance with shopping. Some people had a regular breakfast and lunch visit to support them with their meals and also to check on their well-being.

Requires Improvement

Is the service caring?

Our findings

Our last inspection of RA Care services Limited on 6 January 2016 we found that care plans did not clearly state people's wishes or preferences about their care. There was no evidence that the preferences people discussed during their needs assessments were included and taken into account and the use of inappropriate language was used in people's daily care records. During this inspection we found that some improvements had been made but one person using the service and two relatives told us the care provided was not always carried out in respectful and dignified manner.

One relative told us their family member had lost their dentures and became emotionally distressed about this. They said that they asked the care worker if they could help them look for these and they refused and just said that they did not have the time. Another relative reported that when the care worker arrived to assist with personal care, the person refused to be supported to take a bath, but the care worker did not ask if their family member required a strip wash or offer support with their food which was a requirement of the care package. They added the care worker did not listen to their family member and said they were unable to understand what was written in the daily records kept in the person's home. One person we spoke to further commented that care workers did not support them with their personal care in a way that promoted their dignity.

Three relatives described the care workers as "caring" and "understanding". They also told us their family members were supported by caring staff and were happy with the care provided. One relative said, "The carers here are brilliant, the carers are lovely people" and another commented "I'm happy with the care they are providing they are consistent and when they come in they always check the book." And one person using the service told us, "They always have time to talk with me I really enjoy their company."

The registered manager explained that the people they supported lived with their relatives who were involved in the development and review of people's care plans where the person agreed to this.

People's individual preferences and wishes were recorded, advising care staff about their preferred methods of communication and how they would like to be greeted. For example, if they preferred to be called by their first name or another familiar name. Where people required specific gender support we found this was acted on.

The registered manager told us they tried to ensure people received care from the same care workers so that they were supported and care for by staff who knew them well. Care workers confirmed that they generally had a regular group of people they supported and people's relatives confirmed this.

Inadequate

Is the service responsive?

Our findings

Our comprehensive inspection completed on 6 January 2016 found the care plans were incomplete and did not adequately reflect people's individual needs. They were not reviewed and updated to reflect people's changing needs; daily care notes lacked sufficient detail about people's needs; there was lack of clarity over the frequency of times and visits against the care records and complaints were not followed up.

At this inspection, we found that some work had been undertaken to partially address this, however, we identified further shortfalls.

People's relatives told us that care workers did not miss their calls and the regular staff turned up on time and provided the required support. One relative said, "Lately we get regular staff, I think that is so important." A relative said, "They turn up and don't miss." However, two relatives told us a care worker left their care calls early and said the care provided was carried out hurriedly. One relative said, "The morning care worker is on time but the lunchtime carer is always panicky and it stresses [my family member] out, as they have to relieve another carer in the evening." The provider did not use an electronic call monitoring system, but told us they had plans in place to commence using this after all staff had received training on the software, that was due to begin the following week. He further explained that they used a texting service to check if staff arrived to their scheduled visits on time. We asked the registered manager for a copy of the staff weekly rotas and he told us they did not have rotas because the regular care workers went to the same care calls frequently and rarely missed visits. We looked at sample of the daily care records and timesheets and saw there was a lack of clarity over the frequency and times of visits when comparing these against the daily care records and timesheets. For example, In the daily record for one person we found that the care worker had not signed the record for the tea time visit on 1, 8, 14 and 22 September 2016 to confirm the call had been carried out. In another record, care workers were required to tick the care tasks that were carried out and found some of these were not completed and the reasons for this were not recorded in their daily care records. Therefore we could not be assured that people were receiving the required care and support to meet their individual needs.

In addition to this, call times were typed up in ink within the daily log books kept in people's homes which meant we could not be assured of the times the care worker arrived and left the care calls in people's homes. The registered manager told us that when care workers completed their visits they returned the daily log books to the office where the office staff typed the times in so they were legible. They said this had been discussed and agreed with people's relatives and they had reported no concerns that care workers did not arrive at the scheduled times. However, one relative told us that a care worker had taken the daily log book out of their home without them giving them permission to do so. The registered manager explained they no longer typed up the times of the care calls and showed us daily logs to demonstrate that care workers were now writing in the times of their care calls. We crossed referenced these records and still found that the call times written by the care workers did not match visit times recorded in the timesheets. Therefore we could not be assured that people's individual needs were fully met.

The registered manager told us he completed assessments prior to people's care packages being

implemented. One person told us someone from the office had come out to meet with them and they had completed their care plan with the information from the meeting. A relative also told us, "The care worker came and brought it along when [my family member] started with the agency." Despite this feedback when we cross referenced people's care plans and daily records we found a number of inconsistencies. For example, we saw discrepancies between correspondence from the local authorities and the provider's records in relation to the start dates for care packages and times of calls. In addition to this, we found inaccurate information, for example, in one person's file that the care package commenced on 7 July 2016, however a feedback form completed for the person was dated 19 February 2016 before the care commenced. In another care plan it was recorded that this was due to be reviewed on 3 October 2016, however this had not been done. Daily notes had been printed out and contained hand written corrections over dates, for example where a person's relative had been informed of their family member's hospital admission. Furthermore, we found that care records had not been updated to reflect people's changing needs. There were inconsistencies of this kind in all of the care records we looked at and this had been pointed out during the last inspection. The registered manager acknowledged these errors in the care records. After the inspection the registered manager sent of an audit of the daily care records, however this did not identify any of the errors we found in in the daily records, timesheets or care plans.

The issues above increased the risk of people receiving inadequate care that didn't meet their individual needs. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans were personalised to reflect peoples' preferences such as their hobbies and interests and choices in relation to their care. They described people's likes and dislikes, if they had any pets and the involvement of their relatives with their care needs. Initial call sheets were placed on the front of the file to determine when the care had commenced with the provider and we found a service user guide regarding the care provider in each person's file we viewed.

The provider had a complaints policy in place and the registered manager showed us a complaints file and we saw that complaints had been responded and acted on. Two relatives told us they had concerns but had not raised this with the registered manager but knew how to do this. Three relatives we spoke to told us they had no concerns regarding the care that was carried out and would report any concerns to the registered manager and felt confident these would be resolved.

Inadequate

Is the service well-led?

Our findings

During our last inspection on 6 January 2016 we found the provider's quality assurance systems were ineffective as they failed to identify and address shortfalls, and failed to identify any patterns or trends that would highlight potential risks or areas for development. Overall there was a lack of effective systems for monitoring, and improving the quality and safety of the service provided. There had been a failure to recognise and comply with the legal obligation to notify CQC of allegations of abuse.

At this inspection we identified six breaches of regulations, many of which were continuing breaches from our previous inspection. The provider had failed to effectively implement their action plan to ensure that the required improvements were made. We saw no evidence that the provider's monitoring systems would identify any patterns or trends that would highlight potential risks or areas to ensure that action was taken to help prevent a reoccurrence.

The registered manager had delegated tasks to staff but we saw no evidence to show that the registered manager monitored the performance of staff to ensure that tasks were either fully completed to the required standard. People's care records did not provide and accurate and up to date records of their care needs or sufficient guidance for staff about how to meet these. Following our previous inspection on 6 January 2016, the provider recruited a quality assurance manager to support improvement at the service. They had identified concerns and prioritised work to address them; including reviewing risk assessments and care plans, and conducting spot checks in people's homes. However, this work had not been completed at the time of our inspection and we were informed that the quality assurance manager had left. Local authority monitoring visits had also identified concerns about the operation of the service.

The failure to operate effective systems to assess, monitor and improve the quality and safety of the service demonstrates a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us staff meetings were held every two months and further explained that at times it was difficult to see all the staff together and therefore one to one meetings were planned with care workers. We were shown the agenda items discussed during these meetings that included safeguarding, customer service, efficiency and time management; however there were no minutes of these meetings to demonstrate what had been discussed with staff and any resulting actions. We saw one action point raised with a care worker to make sure all care records were completed and timesheets signed. This meant that staff may not have been given the opportunity to share information and receive important updates about their work and any changes within the service.

The registered manager told us he conducted spot checks in people's homes every four to six weeks and we saw this was carried out. Survey forms were sent to people to complete and all the results showed that these were positive. The provider had conducted employee feedback forms on all the staff and these were also positive and informed us they enjoyed working with people who used the service and stated that they were felt supported. However, there was no evidence to demonstrate how this information was used to effect

improvements to the service.