Wilberforce Healthcare UK Limited

Wilberforce Healthcare

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Wilberforce Healthcare provides a service to people living in the community who are over the age of 18 who may have dementia care needs, a learning disability, mental health needs or a physical disability.

The office is based in Hull city centre and is accessible to people with physical or mobility difficulties.

This unannounced inspection took place on 10 and 13 October 2016. The inspection team consisted of two adult social care inspectors. At the last inspection of the service in December 2015, the service was complaint with all of the regulations we inspected at that time.

The service had a registered manager which is a requirement if their registration. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

During this comprehensive inspection we found multiple breaches of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014 and a breach of the Health and Social Care Act 2008 [Registration] Regulations 2009. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any Representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the registered provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of Inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the registered provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of Inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

The service could not deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people who used the service. The registered provider could not deliver commissioned care to 17 people totalling 102 care calls between 8 and 9 October 2016. The registered

provider had to permanently hand back care packages for 21 people to the local authority commissioners, Kingston upon Hull City Council as they did not have enough staff meet their needs.

People who used the service were exposed to the risk of abuse by way of neglect because the registered provider failed to ensure the service could deploy sufficient numbers of staff to meet their assessed needs.

People did not receive safe care and treatment. The call monitoring records we reviewed provided clear evidence that staff consistently failed to stay for the full duration of the care call. People who had been assessed as requiring the support of staff for 30 minutes had their care delivered in less than four minutes. Staff failed to support people at agreed times, arriving up to 179 minutes late and up to 177 minutes early to care calls. Vulnerable people who required time specific medicines, repositioning to reduce the possibility of developing pressure sores or fundamental care such as personal care and toileting did not receive safe care and treatment because of the registered provider's failure to ensure staff delivered care and support at agreed times.

Safe recruitment practices were not established and operated. One member of staff had been employed without a Disclosure and Barring Service (DBS) check being undertaken and another member of staff's DBS check showed they had been charged with battery and handling stolen goods. The registered provider had failed to ensure a risk assessment was in place to mitigate risks regarding employing a person with recent criminal convictions or document the reason for their employment. This exposed people who used the service to the risk of being supported by staff who may not be suitable to work with vulnerable adults.

Care plans had not been created for two people who used the service and other people's care plans failed to reflect people's current support needs. Subsequently, risk assessments had not been created to manage and reduce where possible known risks to ensure people received the care they required in a consistently safe and effective way.

The registered provider's business continuity plan failed to include relevant information such as how to manage staffing shortages.

Staff were not supported to deliver high quality effective care. Newly recruited staff with previous experience working in the care sector were allowed to support people without having their skills and abilities checked. This exposed people to receiving support from unskilled staff.

Staff did not receive adequate supervision, monitoring or appraisal and their competencies and abilities were not assessed on a regular basis. The registered provider failed to assess the competency of care staff and we did not see any evidence that checks were occurring. Records showed some staff had not had their abilities assessed by the registered provider since 2014. There was minimal evidence of one to one support and no evidence of yearly appraisals taking place.

People who used the service told us they were supported to eat and drink sufficiently but raised concerns about staff failing to arrive at specified times adversely impacted on when they ate their meals.

People confirmed that they had consented to the care and support they received.

Staff did not always support people in a caring way. Call monitoring records showed staff had changed the order of their care calls which meant people did not receive their care and support at agreed times. Staff leaving care calls early impacted on how care tasks were delivered and showed a lack of support for the people who used the service.

Information was not available to staff regarding people's life histories which would have enabled them to engage people in meaningful conversations.

Appropriate action was not taken when people's needs changed or developed. When people had returned from hospital admissions assessments were not completed to ensure staff were fully aware of people's needs.

When people raised concerns or made complaints they were not always responded to as required. Investigations into complaints were not completed in a robust or effective manner and action was not taken to learn from complaints which could have prevented similar issues reoccurring.

The registered provider's quality monitoring systems were inadequate. There was no evidence to show that auditing of care plans, risk assessments, staff training and supervision, care delivery, staffing hours, recruitment or complaints was carried out within the service.

The Commission were not made aware of notifiable events that occurred within the service as required.

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 registered provider could not deploy sufficient numbers of staff to meet the needs of the people who used the service.

Staff did not deliver care and support at agreed times and left some 30 minute care calls after less than four minutes.

Risks assessments were not in place to ensure the safe and effective delivery of care. Plans were not in place to respond to emergency situations.

People did not always receive their prescribed medicines at appropriate times or at required intervals.

Safe recruitment practices were not established and operated and appropriate evidence was not available to support why staff with a criminal record had been recruited.

Is the service effective?

Inadequate

The service was not effective. The registered provider failed to support staff and ensure they had the skills and abilities to deliver people's care effectively.

Staff did not receive adequate amounts of one to one support or yearly appraisals.

People were supported to eat and drink sufficiently but staff arriving early and late for calls impacted on when people ate their meals.

Consent was gained before care and support was delivered.

Is the service caring?

Requires Improvement

The service was not always caring. Staff's actions did not demonstrate a caring approach and lacked consideration for people needs.

People were not always treated with dignity and respect.

Appropriate information was not available to staff to ensure they supported people in a person centred way, in line with their preferences.

People who used the service said staff were caring

Is the service responsive?

Inadequate

The service was not responsive. Care plans were not reflective of people's needs. Reviews of care were not undertaken as people's needs changed and developed.

The registered provider failed to respond to complaints in a timely manner. Concerns and complaints were not used to improve the overall quality of the service.

Is the service well-led?

Inadequate

The service was not well-led. The systems and processes used to monitor and improve the quality of service delivery were inadequate.

The registered provider failed to notify the CQC of specific events that occurred within the service which affected the safe delivery of care.

The service had a registered manager.

Wilberforce Healthcare

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 registered provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 10 and 13 October 2016. The inspection team consisted of two adult social care inspectors.

Before the inspection, we were contacted by the local authority commissioners, Kingston upon Hull City Council, who informed us they had been notified by the registered provider of the service's inability to complete 102 scheduled care calls on 8 and 9 October 2016.

We reviewed all of the information we held regarding the service including notifications and previous inspection reports.

During the inspection, we spoke with the registered provider, the office manager, the residential manager and five members of staff including office staff. After the inspection we spoke with nine people who used the service and five of their relatives to gain their views.

We looked at eight people's care plans along with the associated risk assessments and Medication Administration Records (MARs). We also looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) to ensure that when people were assessed as lacking capacity to make informed decisions themselves or when they were deprived of their liberty, actions were taken in their best interest.

We also looked at a selection of documentation pertaining to the management and running of the service. This included action plans, call time monitoring figures, the business continuity plan, recruitment information for seven members of staff, the staff training records as well as a number the registered provider's policies and procedures.

Inadequate

Is the service safe?

Our findings

People who used the service told us they did not feel safe. One person said, "I wanted someone to come and help me out of bed in the mornings and to help me get washed and ready for the day. My call was supposed to be at 9am but they [the staff] would come at all sorts of times, they came at 7.00am and I had to get up in the dark. I wasn't reassured knowing someone was coming I was more worried about when it would be." Another person said, "The staff didn't make me feel safe, they were always rushing and everything was always done so quickly." A relative told us, "We never knew who was going to turn up or what time it would be, we all needed someone to rely on and we certainly didn't get that." A second relative safe, "We didn't feel that Mum was safe because the staff weren't very honest, they would write the time they arrived and when they left in the book, they wrote all the things they had done and we knew that they weren't true, they never arrived on time, they always left early and half the things never got done."

The registered provider could not deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people who used the service. On 7 October 2016 the Care Quality Commission were notified by the local authority commissioners, Kingston upon Hull City Council, of the registered provider's inability to deliver care and support to 17 people during the weekend of 8 and 9 October, which equated to over 100 care calls. Due to staffing issues experienced by the registered provider and their failure to provide assurance of their on-going ability to deliver safe and effective care to the aforementioned 17 people, the local authority commissioners, Kingston upon Hull City Council made the decision to permanently reallocate them to another homecare provider.

The office manager told us, "The weekend has been very difficult; if I'm honest it's been rubbish. We had eight staff leave on Friday and another four over the weekend. I am going to have to give another four people back [to the local authority commissioners, Kingston upon Hull City Council] because I can't cover their calls. I would rather hand them back and know that someone will go then try and keep them and struggle to find staff who can to cover." The registered provider clarified their current staffing levels, they explained from the 45 staff employed to deliver care and support in the community, 15 had recently resigned, seven were on holiday and four on sick leave.

The above information contributed to the breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, staffing. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

People who used the service were exposed to the risk of neglect and suffered from neglectful practices because staff failed to deliver care at agreed times and stay for the allotted amount of time to safely and effectively deliver the care and supported people required. The registered provider described a person who used the service as having high needs which included, 'very vulnerable, requires full assistance with personal care, suffers with epilepsy, suffers epileptic seizures daily and lives alone. Despite this understanding of the person's needs care staff arrived to a 30 minute care call 164 minutes late and left the call after less than four minutes. If the person had suffered an epileptic seizure and required medical attention staff arriving nearly three hours late would have impacted on the time they became aware of the incident and subsequently

delayed the time they called for support. This was placing the person at significant risk of harm.

The registered provider described a second person who used the service as having high needs which included, 'a cancer suffer, bed bound, prone to sores and needs repositioning throughout the day by two care staff using a hoist.' Records showed on more than once occasion staff arrived over an hour and a half late to deliver care, which increased the time between positional changes and increased the possibility of the person developing pressure related sores. A third person was described as having high needs which included, 'fully dependent on staff for all personal care needs and medication, has on set dementia, confused and lives alone.' Staff arrived to the call 138 minutes which meant the person had to wait to receive personal care and their prescribed medication was not administered when required.

Call monitoring records showed that staff consistently left care calls early and highlighted their lack of ability to deliver care at agreed times. From a sample of 561 calls delivered over 14, 15 and 16 October 2016, 81 calls were delivered in less than half of the time staff would need to deliver the care the person required. 52 calls were completed in less than 10 minutes and 19 were completed in less than five minutes. Records also showed staff arrived up to 179 minutes late and up to 177 minutes early to care calls. We spoke with the registered provider about staff not staying for the full duration of care calls and were told, "We have not had the systems to be able to see that staff were turning up late and leaving early, we could have done spot checks and found out but obviously we haven't and the staff have let us down."

People were exposed to the risk of abuse by way of neglect because the registered provider could not deploy sufficient numbers of staff. The actions of the local authority commissioners, Kingston upon Hull City Council, ensured 21 people did not suffer abuse by way of neglect because they were able to reallocate care calls that the registered provider could not deliver.

The above information demonstrated a breach of Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safeguarding service users from abuse and improper treatment. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

People who used the service did not receive safe care and treatment. The service had failed to effectively assess the risks to the health and safety of people who used the service and failed to do all that was reasonably practicable to mitigate risks. For example, one person's moving and handling risk assessment completed by the service stated they had no moving and handling needs even though they were paralyzed from the waist down and had been assessed as requiring support from care staff to hoist them from their bed to their wheelchair by the local authority commissioners. Staff were not provided with appropriate guidance to enable them to deliver care and support in the safest way.

Staff told us that the same person was often intoxicated, refused care and was verbally aggressive threatening physical violence. No risk assessments had been developed to enable staff to effectively support and deliver care when the person was intoxicated or aggressive and no action was taken by the service to escalate the concerns that staff could not deliver the care and support the person had been assessed as requiring.

We reviewed a safeguarding alert received by the local authority safeguarding team which stated another person who used the service had been discharged from hospital, fallen at home and were subsequently re-admitted to hospital. The alert also highlighted the person had open wounds on their legs which were weeping. When we reviewed the person's care plan it contained no information regarding the hospital admissions or leg ulcers/wounds, no assessments were completed to ensure the service were aware of and

had mitigated the risks to the person as their needs had changed. The care plan stated the person had 'bad mobility' but no risk assessment regarding falls prevention had been created.

A third person's care plan failed to state what their care and support needs were and contained no risk assessments. The registered provider had failed to record or mitigate risks and provided no guidance to enable staff to deliver care and support safely.

Effective action was not taken by staff to ensure known risks were mitigated. A fourth person who had to be repositioned by staff with the use of a hoist at set intervals to reduce the possibility of developing pressure sores did not receive the care they required because staff did not attend the call on time. Records showed staff regularly arrived nearly two hours late for a care call scheduled for 1.30pm, but arrived as scheduled for a 4.00pm care call. This meant the person was not repositioned at the required times which increased the possibility of them developing pressure related injuries.

The registered provider's business continuity plan stated, 'the registered manager in overall charge of care staff and service users'. However, there was no information or plan regarding how to deal with a foreseeable emergency such as the loss of staff. At a meeting after the inspection the registered manager told us, "If I was here [at the service] when we lost the staff I would have brought staff from our agency across to cover the calls and we wouldn't have had this problem." The registered provider failed to ensure their business continuity plan contained relevant, accurate and up to date information and instructions to be followed in the event of a foreseeable emergency which meant known risks were not mitigated and increased the possibility of frail and vulnerable people not receiving the care and support they required.

The above information contributed to the breach of Regulation 12 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

We reviewed seven staff files and assessed the processes used by the registered provider to assure themselves that prospective staff had not been deemed unsuitable to work with vulnerable adults. We found suitable references and confirmation that Disclosure and Barring Service (DBS) checks had been completed in six of the files. A DBS check is completed during the recruitment stage to determine whether an individual has a criminal conviction, which may prevent them from working with vulnerable people. This helped to ensure people were supported by staff who had not been deemed unsuitable to work with vulnerable adults. However, one of the DBS checks showed the person had a range of recent convictions including, battery, occasioning bodily harm and handling stolen goods. There was no risk assessment or record of any conversation with the staff member to support the registered provider's decision making regarding why they had deemed the person to be suitable to provide care and support to vulnerable people in their own homes. The registered manager told us, "I have spoken to [the member of staff] about their convictions, they explained what happened and I was happy with what they said. I should have completed a risk assessment; I don't know why I haven't."

The seventh staff file did not contain a DBS check or references. The registered provider told us the member of staff started working at the service in January 2016; then left in the service and found alternative employment in April 2016 before returning to the service in June 2016. There was no evidence to show that references had been obtained for either term of employment or that a DBS check had been undertaken. The registered provider told us, [Name of the member of staff] has a DBS from the first time we employed her, I don't know why we don't have references, we should have." The registered manager said, "I am so strict about DBS checks, when [Name of the member of staff] told me they didn't have one I couldn't believe it."

Failing to ensure relevant checks have been completed before prospective staff commenced their employment, exposed people who used the service to the risk of harm by way of receiving care and support from staff who were not suitable to work in the care industry.

The above information demonstrated a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, fit and proper persons employed. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

People who used the service did not always receive their medicines as prescribed. Staff arriving early and late for scheduled care calls meant people did not have their medicines administered when required. One person who used the service, described by the registered provider as having high needs which included, 'suffers with Parkinson's disease and requires vital medication three hourly'. Call monitoring records showed that staff arrived 101 minutes late to a schedule call which meant the person did not have their medicines at the required three hourly intervals.

We reviewed a number of medication administration records (MARs) and saw that they had been completed with minimal omissions. When staff had failed to record that medication had been administered action was taken by the registered provider such as checking against the daily notes and speaking with the staff involved to ensure further incidents did not occur. However, a member of office staff told us that MARs and daily records stayed in people's homes for six weeks before being returned to the office. This meant if staff failed to provide medication as prescribed or made errors with administration this would not be picked up by the service until potentially six weeks after the error occurred. A person who used the service said, "They [the care staff] give me my medicine every day, I just take it with a glass of water." Another person said, "I got mine [medicines] whenever they arrived, if they didn't come, which happened every now and then, I just didn't have them that day."

Inadequate

Is the service effective?

Our findings

When we asked people who used the service and their relatives if they were supported by capable staff we received mixed responses. One person said, "I can't grumble I thought the girls [care staff] were very good". However, other people commented, "I don't think they are well trained, they never seemed to know what they were doing", "I had to complain because the girl who came to see me would help me get washed, she always wore gloves and she would do my feet for me then go and do the washing up with the gloves still on, I had to wash up after she had gone because I didn't think it was hygienic", "The staff were nice but they would always ask me what I needed doing, they never seemed to remember" and "All I can say is I have moved to another company and I am really, really happy with the new staff, they are very professional, they know what needs doing and are a pleasure to have. Not like others I could mention."

People who used the service were not supported by staff who had the skills and abilities to meet their needs. When new staff were employed by the registered provider they completed a range of in house training. However, a number of files we saw had training certificates from other training providers. The training residential manager told us, "I verify all the training and will do spot checks to see they [the new staff] can do everything right." We checked the staff file for a newly recruited member of staff and saw their file contained an email from their previous employer stating the training they had completed and the year it was undertaken. There was no evidence available to support this such as certificates and there was no evidence to show that the registered provider had taken any action to assure themselves of the staff member's skills and abilities such as spot checks or monitoring.

Staff practice was not reviewed to ensure an effective level of care and support was delivered. We asked the registered provider to supply evidence that staff had been supported during supervisions or appraisals, we were told that the information we would be stored in the back of the staff files. None of the seven staff files we looked at contained an annual appraisal, even though staff had worked for the registered provider since 2013. There were no supervision records available in any of the staff files we looked at. The registered provider said, "If they aren't in the files then they can't have been done, I don't have an explanation why."

The registered provider failed to support staff effectively and did not assess their skills and abilities as required. Failing to support staff and provide regular supervision, appraisal and mentorship can lead to opportunities in their development being missed as well as areas that require improvement not being identified and subsequently continuing to the detriment of the people who used the service.

The registered provider told us that the registered manager had spoken with every member of care staff regarding imminent changes to the way they were paid. When we spoke with the registered manager they confirmed this but said the conversations had not been recorded and they could not provide any evidence to support their statement.

The above information contributed to the breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, staffing. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

Staff were expected to carry out tasks they had not been trained to complete. For example, one member of staff completed assessments of people's needs before producing care plans and risk assessments that staff required to deliver care and support consistently and effectively. However, when we checked their training records they had not completed training in this area and had not been able to produce care plans that reflected people's needs or risk assessments that mitigated known risk effectively.

The above information contributed to the breach of Regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

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, 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. For people in their own homes and in the community who needed help with making decisions, an application should be made to the Court of Protection. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. People we spoke with confirmed that their consent had been obtained before care and support was delivered.

People who used the service confirmed they were supported to have sufficient amounts to eat and drink, but raised concerns about staff not turning up at agreed times and the impact this had on their dietary intake. One person said, "I like simple food so the carer doesn't need to have been on master chef, the problem I have is they are supposed to make my breakfast so sometimes [when care staff arrive late]I don't get to eat anything until after 10.00am." A relative we spoke with said, "My sister is diabetic so needs food regularly so that she can take her medication, when they turn up late or just don't bother turning up it has a huge impact for her."

We saw that people who used the service were supported by a range of professionals such as community nurses and GPs. One person who used the service said, "I see a nurse regularly for my legs, she comes to see me because I can't really leave the house."

Requires Improvement

Is the service caring?

Our findings

People who used the service provided a range of responses when we asked them if the staff who supported them were caring. One person said, "The girls were nice enough but we saw a different one most days, we had a regular carer but she left and we were never really happy after that." Another person said, "Don't get me wrong, I think their hearts were in the right place but they weren't supported by the office, and most of them didn't really know what they were doing." Other people said, "I think they were caring but it's difficult for me when I think someone is coming to make my lunch at 12.30pm and they don't turn up until after 3.00pm. That's my biggest complaint they were never here when they said they would be", "I never had a problem with the carers, I saw the same one regularly and we got on well" and "The carers were lovely, I can't say the same for the office staff."

People who used the service were not always supported by caring and attentive staff who treated them with dignity and respect. It was evident from the call monitoring records we saw that some staff had changed the order of their allocated care calls. This meant that people who expected a care call at specifically agreed times were made to wait for the care and support they had been assessed as requiring because staff decided to go to other calls first. A relative we spoke with said, "We rang once to see where they were and were told the carer was sat at the traffic lights but they could see the house and would be there soon, they didn't turn up for two hours, if they said they couldn't make it that's one thing but they just lied which is unforgiveable really."

Staff did not treat people respectfully and did not always show sensitivity or compassion when delivering care. Call monitoring records showed staff consistently left calls early, which meant people did not receive all of the care and support they had been assessed as requiring. Care and support was regularly delivered in half of the allocated time which meant staff either failed to complete all of the required tasks or rushed through them which would have impacted on people's levels of independence and social inclusion. A person who used the service told us, "I don't like to make a fuss but sometimes they [the carers] are the only people I will see and the never stay very long or just sit and talk to me."

People who used the service did not receive person centred care that met their needs and reflected their preferences. Staff did not always know the people they were caring for and supporting, because people's care plans lacked relevant information. The care plans we saw did not contain personal information about people such as their hobbies and interests, their family lives or the previous occupations, which would have enabled staff to engage people in meaningful conversations. One care plan contained no information about the person's needs so staff delivering care would not have known what the person required assistance with or their preferences in relation to their care. The registered provider told us, "We should have pen pictures in every care plan. The staff need that information."

The above information demonstrated a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person centred care. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

The registered provider failed to ensure the service demonstrated a caring approach and put the people who used the service at the centre of everything they did. We saw that complaints and concerns had not been responded to in a timely way and people did not receive an apology or explanation when care calls were missed. We spoke with the registered provider regarding staff not staying for the full duration of care calls we were told, "We have not had the systems to be able to see that staff were turning up late and leaving early, we could have done spot checks and found out but obviously we haven't and the staff have let us down."

Information was stored safely. Care plans and other private and sensitive information were stored in locked cabinets in the main office. The registered provider ensured information held electronic was only accessible to relevant people and all computers required a password and personalised log-in.

Inadequate

Is the service responsive?

Our findings

People who used the service and their relatives confirmed they were involved in the initial assessment and the planning of their care. One person said, "Someone came round and they asked me lots of questions, they said they would make a care plan from the things we had talked about, but for the first three weeks I didn't have anything in my house except a scrap of paper where the carers write what they had done when they were here." Another person said, "I was with them [the registered provider] for years and I never had a care plan, no-one came and asked me what help I needed, they [the registered provider] really weren't up to much." A relative told us, "We had someone from the company and social services come round and they asked lots of questions they came back a couple of days later with a care plan" and went on to say, "Out of the 10 different carers we had I think two of them looked at it, none of the others did."

People told us they knew how to raise complaints and concerns. One person said, "My daughter complained twice, once when no one turned up an then when someone came about 5 hours late, she wasn't happy but nothing ever changed they still turned up at all different times." Another person said, "All my complaints fell on deaf ears, they just weren't bothered. A relative said, "The response to my complaints was appalling, the office staff just didn't seem care, they would say they would ring you back but didn't, they would say they would get back to me and they never did."

The registered provider told us that people's care needs were reviewed on an annual basis. However, the care plans we saw were produced for people who had recently joined the service so an annual review had not been completed. A relative we spoke with confirmed reviews were completed, they said, "I think we have been with them for about a year and a half, they came and did a review, they just asked how things were going and if we needed anything changing."

People did not have care plans that reflected their current levels of needs or included their preferences for how care and support should be delivered. One person's care file contained extremely limited information. There was no assessment of their care and support needs, no care plans had been created and there was no guidance to enable staff to meet their needs in line with their preferences. Another person did not have a care plan in their home; this meant there was no information for staff at the point of care.

Staff told us one person who used the service could become verbally aggressive and refuse care and support. When we reviewed the person's care file there was no reference to their behaviour or refusal of support; the care plan contained no guidance or support strategies that were known to be successful when the person refused care or instruction regarding what action staff should take if the person became aggressive. Records showed the person had open wounds on their legs and were admitted to hospital following a fall in their own home. Their care plan had no information regarding the hospital admissions or leg ulcers/wounds; there was no information about how the injuries affected the person or how the person preferred to be supported. We showed the care plan to the registered provider who commented, "I am absolutely disgusted with the care plans you have shown me."

Another person experienced problems with alcohol and required staff to support them to transfer using a

hoist, to deliver personal care and provide social stimulation that would prevent them from becoming isolated. Their care plan stated they required transferring with a hoist but provided no further guidance in relation to their preferences or safe use of the hoist. There was no information regarding their alcohol intake and no guidance to ensure staff could recognise when the person was intoxicated or what actions to take when this occurred.

After this inspection the registered manager informed us that they had reviewed every care plan and a minimum of 30 would need to be updated to ensure they reflected people current needs and contained relevant instructions to enable staff to deliver care and support effectively.

The above information demonstrated a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, person centred care. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

The registered provider failed to appropriately record and respond to complaints. The service's complaints file contained seven complaints but due to the poor record keeping and lack of information made in the service we could not conclusively determine when or how the complaints were received. Several complaints were not dated but records showed one was raised in August 2016. Two of the complaints showed that minimal work had been undertaken to investigate the complaint, but there was no response letter drafted and no contact had been made with the complainant to acknowledge their concerns or provide any form of response or apology. The other five complaints contained no information except for the complaint, no acknowledgement, no investigation and no response.

The local authority commissioning team told us they had received 14 complaints since August 2016 regarding the service which included staff's lack of professionalism, staff's attitudes, missed calls, theft, staff entering people's properties at unexpected times such as 2.30am and staff not being gentle or considerate during care tasks.

A person who used the service raised a complaint during a telephone review conducted by the registered provider. The complainant stated they were not sure when care staff were going to arrive and on one occasion staff failed to turn up completely. We discussed this with the registered provider as it had not been logged as a complaint. The registered provider stated they were unaware of the complaint and due to this no action had been taken to investigate or offer an apology to the complainant.

The service had failed to respond to complaints as required, had failed to complete internal investigations and had subsequently failed to learn from any of the concerns raised which would have enabled them to improve the service and prevent future complaints.

The above information demonstrated a breach of Regulation 16 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, receiving and acting on complaints. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

Inadequate

Is the service well-led?

Our findings

People who used the service told us the service was not well-led. A relative we spoke with said, "They missed the first call they were supposed to do and then things went downhill from there, that's how bad it was." A person who used the service said, "The office staff were rubbish and rude" and "I didn't think much to the company if I'm really honest." A second person said, "They lost their best staff, when we first started with them they were smashing, we never had any problems but then something happened and they never knew what was going on, they didn't turn up or turned up at the wrong time, the office didn't seem to know what day it was sometimes."

The registered provider did not operate effective governance systems and relied upon ad-hoc checks to monitor the quality of service delivery. The registered provider explained, "When we got the contract we doubled in size, we went from about 700 hours to nearly 1400. Our processes are just not good enough." The registered manager told us, "No one is at fault here except us, I have taken my foot off the pedal and I know that."

The registered provider failed to monitor the care and support delivered to people who used the service which enabled staff's actions including; leaving calls after less than four minutes, changing call times without authorisation and arriving to deliver care over two hours late and up to two hours early; to become custom and practise.

When we asked the registered provider how they monitored the level of care and support delivered by staff they told us that spot checks and telephone review were conducted regularly. When we checked the staff files where the registered provider told us spot checks were stored, there was minimal evidence that spot checks had occurred, we saw in two staff files spot checks that were undertaken in 2014 and 2015. When we highlighted the distinct lack of evidence to the registered provider they said, "We have had issues with the computer systems so we may have recorded more spot checks but I can't show you that, it's something we have let slip and haven't been doing."

The care plans that we reviewed contained obvious contradictions and lacked sufficient detail to enable staff to deliver safe and effective care. One care plan stated the person required the support of two staff to transfer them from their bed to their wheelchair using a hoist but their moving and handling risk assessment stated they did not have any moving and handling needs. Another person's care plan contained no information regarding their care and support needs. We asked the registered provider how they assured themselves that people's care plans were up to date, accurate and reflected people's needs and were told, "I can't lie, obviously we are not auditing the care plans." The registered manager admitted, "Since we got the contract with Hull it's been too much for us, we have been skipping our own processes, not doing care plans properly, not checking on things. "

We saw that a small number of telephone reviews had been conducted in September 2016 and noted some people who used the service had provided positive comments. The feedback from people had not been collated to ensure learning could be achieved and any good practice was adopted to improve the overall

service. One person expressed their dis-satisfaction with the service they had received and no action had been taken to follow this up. The registered provider failed to learn from the feedback or take action to ensure the continual improvement of the service.

We raised concerns regarding the lack of relevant information in staff files such as references and risk assessments regarding particular pieces of recruitment. The registered provider explained, "We have a risk assessment form and that should be filled in when we find something on a DBS check, I don't know why it hasn't been done" and "No one can be checking the files because they would have seen there was no risk assessment."

Complete and contemporaneous records were not held regarding each person who used the service. Two people who used the service did not have care plans. The registered provider told us, "The first person we only looked after for a short time, the council [the local authority commissioners, Kingston upon Hull City Council] need them supporting at short notice. The other person, I can't say why, I don't know what must have happened."

The above information demonstrated a breach of Regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

On Friday 7 October 2016 the registered provider informed the local authority commissioners, Kingston upon Hull City Council of their inability to deliver care calls to 17 people who used the service on 8 and 9 October 2016 which equated to 102 care calls. The registered provider failed to inform the Commission as required of their inability to prove care and support to people who used the service until 10 October 2016 and this was done after being prompted by CQC inspectors.

The above information demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration Regulations) Regulations 2009, notification of other incidents. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

The registered provider and registered manager were not open and transparent about the issues occurring with the service, they failed to raise concerns to the CQC or local authority commissioners which. The registered manager told us, "I knew we had loads of problems, we knew something serious was going to happen to someone."

As demonstrated throughout this report the registered provider had failed to ensure compliance with regulations 9, 12, 13, 16, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The above information demonstrated a breach of regulation 8 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, general. We are currently considering our regulatory response to this breach and will report on any action once it is completed.