

iCall Care Limited

iCall Care Office

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

This inspection took place on 19 and 20 January 2016 and was announced. The provider was given 48 hours' notice because the location provides domiciliary care service and we needed to be sure that someone would be at the office.

iCall Care Office is a domiciliary care service providing care and support to people living in their own homes. The office is based in the city of Leicester and the service currently provides care and support to people living in Leicester. At the time of our inspection there were 26 people using the service who received personal care and social support.

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

People told us they felt safe with the staff that supported them. Staff were trained in safeguarding (protecting people who used care services from abuse) procedures and were confident to report concerns about people's safety to the registered manager.

People's safety was not protected because staff were not recruited properly and pre-employment checks were not carried out. Improvements were also needed to staff training, supervision and support because the systems were not in place to monitor and support staff effectively.

Risks to people health and safety in relation to the care and support they needed was not assessed properly. Measures to manage risk were not always detailed sufficiently in the plan of care. People's care was not monitored or reviewed regularly and changes to their needs were not always acted upon. This meant that people received unsafe or inappropriate care.

The service had sufficient staff to meet people's needs. People's individual requirements were matched where possible, with any known requirements such as individual preferences, cultural or diverse needs.

People were prompted to take their medicines by staff where people's assessed needs and care plans required this. Staff supported people to liaise with health care professionals if there were any concerns about their health.

People told us that staff sought consent before they were helped and that staff always respected their choices and decisions. However, improvements were needed to ensure the registered manager and staff understood their responsibilities and requirement to protect people under the Mental Capacity Act and Deprivation of Liberty Safeguards.

People had limited opportunity to be involved in decisions made about their care and their views about the quality of service provided. People did not always receive person centred care that was responsive to help maintain their health, safety and wellbeing.

People's privacy and dignity was maintained, their choice of lifestyle was respected and their independence was promoted.

People were confident to raise any issues, concerns or to make complaints. However, the provider's complaint procedure was not transparent and concerns raised were not recorded. Improvements to the service were limited as a result of a complaint.

There was a registered manager in post. The provider policies and procedures had clear guidance, tools and documentations to be used to ensure a quality and safe service was provided but these were not followed. The provider's quality governance and assurance systems were fragmented and ineffective. Confidential information relating to the people who used the service, staff and the management of the service were destroyed. There was no evidence to demonstrate that the provider monitored, reviewed, and took steps to make improvements to the service. Therefore, improvements were needed.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

People told us they felt safe and staff understood their role to report concerns. Further assurance was needed to ensure the registered manager followed the safeguarding procedures when concerns were raised.

Risks to people's health and wellbeing was not properly assessed, managed or monitored.

People were prompted by staff to take their medicines.

There were sufficient staff to support people. However, improvements were needed to the staff recruitment procedures to protect people's safety.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Staff were not adequately trained, supported or supervised to carry out their duties effectively.

The care and treatment people received was not always effective because the requirements under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were not followed to ensure people's legal rights were respected.

Further action was needed to ensure people's nutritional needs were met. People were referred to the relevant health care professionals to promote their health and wellbeing.

Requires Improvement ●

Is the service caring?

The service was caring.

People told us staff were caring, kind and supportive.

People were involved initially to make decision about their care and in the development of their care plans.

Good ●

Is the service responsive?

The service was not always responsive.

People's needs were assessed when they first started to use the service but the care records did not reflect individual wishes, preferences and interests. Changes to people's needs were not promptly assessed.

People, their relatives, staff and health care professionals were not involved in the review of their care needs. Therefore, care plans were not kept up to date and did not always reflect the recommendations made by health care professionals.

People felt confident to make a complaint. However, the procedure was not transparent and improvements were limited.

Requires Improvement ●

Is the service well-led?

The service was not well-led.

The service had a registered manager in post. Improvements were needed to ensure their knowledge and responsibilities to adhere to the provider's policies and procedures to ensure people received quality care and a safe service.

The provider encouraged feedback from people who used the service, their relatives and staff but opportunities were limited.

The provider had a quality assurance and governance system. However, this was neither fully implemented nor effective, which meant improvements were needed.

Inadequate ●

iCall Care Office

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 19 and 20 January 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection was carried out by one inspector.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR) and provide us with the contact details for health care professionals involved in people's care. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was completed and returned to the Care Quality Commission.

We looked at other information sent to us from people who used the service and relatives of people who used the service. We also looked at the information we held about the service, which included concerns and 'notifications' of significant events that affect the health and safety of people who used the service. A notification is information about important events which the service is required to send us by law.

We spoke with two people who used the service, five relatives whose family member used the service and a social care professional. We also spoke with the registered manager, the care coordinator and seven care staff.

We looked at the records of four people who used the service, which included their care plans, risk assessments and the daily wellbeing logs. We also looked at the recruitment and training files for four members of staff, record of complaints, compliments, policies and procedures. We also looked at how the quality of the service was monitored and managed.

Is the service safe?

Our findings

The provider had a system of assessing risk for people before the service provided care and support to meet their needs. People told us that the care coordinator checked the home environment was safe where the care would be provided and developed the care plan to meet their needs. In some instances a copy of the local authority assessment of the person's needs was used to inform the assessment.

We found risks to people's health, safety and wellbeing were not always assessed properly to maintain their safety. The registered manager told us the completed risk assessment document had been destroyed once the care plan had been developed. But the care plans did not always state what, if any, risks had been identified with regards to the home environment, risk of falls and moving and handling where the person required assistance with moving around. Measures were not always identified in relation to how staff were to manage risks to ensure the person's safety. Equipment such as stand aid, hoist or walking frame used in the delivery of care was not always stated.

We asked the registered manager how they communicated the measures to manage risk they told us that they would tell staff due to support the person. That meant any changes to risks or new risks could not be monitored to ensure that the measures continued to be appropriate. We also found there were no plans or guidance for staff to follow should the person require any medical support in the event of an emergency. That meant people could be at risk of receiving unsafe care, as written information and guidance was not available to staff.

Care staff told us they read the care plans kept in people's home and reported any changes to people's health to the care coordinator to re-assess. We found changes in people's needs and potential risks to their health, safety; health and welfare had not been assessed. One person was assessed by the dietician and now requiring a 'soft mashable diet'. Although there was information provided by the dietician kept in the person's file at the service, no further risk assessment had been carried out or an up to date care plan developed with the recommendations made by health care professionals. Furthermore, the care staff we spoke with were not aware of the changes to this person's dietary needs for over a week and the daily wellbeing logs completed by the care staff also showed unsuitable meals were provided. This meant the person received unsafe care which had increased the risks of choking.

We found changes in people's health or the home environment was reported to the registered manager. For instance, one person was no longer hoisted out of bed because a suitable chair was not available. Staff had followed the verbal instructions given by the care coordinator but the risks as a result of the changes had not been assessed and no new care plan developed to ensure staff were aware of the support required to meet the person's needs. This also meant that any new care staff following the existing care plan could potentially provide inappropriate care.

The registered manager and care coordinator told us that they reviewed people's care for the first four weeks and thereafter either six monthly or annually. However, no records were kept of the review meetings. Furthermore when new care plans were developed the new risk assessments and previous care plans were

shredded. Therefore, people could not be assured that their health, safety and wellbeing was effectively monitored.

This was a breach of Regulation 12 (1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our inspection we had received a concern about staff recruitment procedures not being followed. We referred the concern to the provider to investigate and the registered manager confirmed that pre-employment checks were carried out on all staff. This was also confirmed in the PIR sent by the provider.

We looked at the staff recruitment records. We found the provider was not able to satisfactorily demonstrate that they followed the provider's recruitment procedures. Relevant pre-employment checks were not carried out such as the Disclosure and Barring Service (DBS) checks and references from previous employers or any explanation in gaps in employment history. DBS checks help employers make safer recruitment decisions. One member of staff told us they were offered employment on the day of the interview without checks being carried out. This meant people's safety was not assured or protected by the provider's recruitment procedures because checks were not carried out to ensure suitable staff were employed work with people.

This was a breach of Regulation 19(1)(a)(b)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We wanted to find out what steps were taken by the provider to ensure staff understood their responsibilities to keep people safe. Staff we spoke with told us they had received training in safeguarding (protecting people from abuse) policy and two members of staff had relied on the safeguarding training and knowledge gained from their previous place of work in a social care setting. Despite this staff understood their role in how to protect people from harm and abuse and would report the concern to the registered manager and the external agencies such as the local authority or the Care Quality Commission. The registered manager told us they relied on the care coordinator's observations of staff during the spot checks and feedback from the people who used the service or their relatives as to staff's competence.

We found the provider's safeguarding procedure had information as to what is abuse and the registered manager's responsibility to report concerns to the local safeguarding authority. We found from our discussion with the registered manager their knowledge about the safeguarding procedure, importance of maintaining accurate records and the role of external agencies was limited. For instance, the registered manager told us that they would conduct an investigation if a concern was brought to their attention and only report the concern to the external agencies if someone was harmed. We found that the registered manager did not have arrangements for continually reviewing any safeguarding concerns, incidents, accident or complaints. This meant people's safety and wellbeing was not protected because the provider and registered manager was not pro-active or monitored the service or the care delivered. The registered manager assured us they would refresh their knowledge of the safeguarding procedure.

We found there were sufficient numbers of staff to meet people's needs. Care staff were provided with a rota in advance. A relative whose family member uses the service told us that they received a staff rota so they know which staff were due to visit each week. Another said, "[staff's name] is the regular carer we started and is great, always on time and does what's needed."

Arrangements were in place to deal with staff absences. People using the service told they would call the service office if staff were late to a call or absent. The on-call service was provided by the care coordinator who would either arrange for another staff member to attend or would cover the care call if no one was

available. This meant people could be assured their needs would be met.

People we spoke with managed and administered their own medicines, some with support from their relatives, whilst others needed support from the staff. One person told us that staff reminded them to take their medicines at each visit and handed them the dossett box containing medicines, which they took themselves.

Staff told us that their role in supporting people with their medicines was to remind them and record that this had been done in accordance with care plans. We looked at care records for one person whose support included being reminded to take their medicines. The care plan contained information about their medicines and the role of staff in reminding them to take them. Records showed staff had signed to confirm that the person had been reminded to take their medicines. That meant people could be assured that staff supported them to maintain their health.

Is the service effective?

Our findings

Prior to our inspection we had received a concern about staff training being inadequate. We referred this concern to the registered manager to investigate using the provider's complaint procedure. They confirmed that induction and training for staff was in place which was also reported in the PIR sent by the provider.

The registered manager knew staff needed training and support to ensure people's needs were met. However, staff's induction and on-going training varied. One member of staff told us they had induction training which covered a range of topics in the delivery of care followed by shadowing an experienced member of care staff. But this was not the case for other care staff. One member of staff was not trained to use equipment and another had relied on the training and knowledge gained from the previous employment in a social care setting.

There were some training certificates for moving and handling and the common induction standards, which is a set of training that equips staff to understand their role in the delivery of personal care and support. The service had no system to assess the skill mix of the care staff, identify gaps and plan training to ensure the staff had the skills and knowledge they needed. The registered manager was not aware of the Care Certificate. The 'Care Certificate' training covers a set of standards for health and social care staff that provides the knowledge, skills and training to look after people. This meant people may not have the best possible outcome to assure their health and wellbeing because the provider did not have effective, induction, training and support for staff.

Care staff told us they were supported by the care coordinator who also worked alongside them to meet people's care. However, there was no planned support or supervisions whereby they could discuss their work and any training or development needs. Care staff we spoke with had not attended a staff meeting. There was no record of the meetings but care staff were sent a newsletter. The newsletter for December 2015 and January 2016 had reminders for the care staff about maintaining confidentiality, check equipment is safe to use and is serviced and staff to arrive on time at visits where two staff were needed to provide the support and accurate times to be recorded. The registered manager told us that concerns had been raised that care staff were not recording the times accurately. There was no information about training planned or updates on the service development. The lack of effective staff support provided to staff meant the delivery of care and issues could not be discussed or their practices monitored effectively.

This was a breach of Regulation 18(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service and relatives we spoke with told us that staff knew how to support them. One person told us that the care staff who supported them were trained in how to support them and used the hoist correctly. A relative said, "Staff seem to be trained and know how to support [person's name] who has got dementia."

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.

The PIR sent to us by the provider stated that the service had an MCA policy and procedure in place and that the care staff were trained. They also supported one person whose liberty was restricted in the how their care was provided. Despite having procedures in place and we found little evidence that showed that the registered manager and some staff completed MCA because their knowledge was variable and inconsistent. The social care professional also told us that further training and support was needed to ensure everyone at the service understood their responsibilities in relation to MCA. This meant the provider and registered manager could potentially deprive people of their rights and liberty.

We checked whether the service was working within the principles of the MCA. People had signed a contract for the service to provide their care and treatment. However, none of the care plans showed that people or their representatives were involved in the development and none were signed to confirm consent to the care to be provided. This meant people could receive care that they had not agreed to.

We looked the care records for the person whose liberty was reported to be restricted in how their personal care needs were met. We found that the principals of the MCA had not been followed correctly because no capacity assessment was completed and no evidence that a referral was made to the supervisory authority where someone lacked the capacity to make decisions their care. We found no evidence of a best interest meeting where the person's relative and professionals had been involved in making best interest decisions on behalf of that person. It was not clear whether the care that was provided was appropriate and in the person's best interest. This approach meant that people's legal rights and decisions were not respected.

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

Staff told us that the people they supported made their own decisions and that they always asked people if they were ready to be assisted. This was confirmed by the people who used the service and relatives we spoke with. One person told us that staff would ask them if they were ready to be helped and only then in line with the care plan and their wishes. This meant that staff helped people only when permitted to do so.

One person told us the care staff encouraged them to eat healthy meals. We spoke with people's relatives and a friend. A relative whose family member needed assistance with their meals told us that care staff heated the prepared meals that met their family member's cultural dietary needs. Another told us they purchased enough snacks, drinks and meals that could be microwaved or heated up other ways. That helped to ensure their family member's nutritional needs were met because staff were able to prepare drinks and snacks that the person liked.

People's care records we looked at detailed the support the person required and their preferred choices for food and drink. One person was referred to the dietician because of swallowing difficulties and required a soft diet. Although there was information about how to prepare a soft diet kept in the person's care file the plan of care had not been updated and the daily wellbeing logs completed by the staff showed that the care staff prepared meals that were not suitable for the person's health. This was raised with the care coordinator who assured us action would be taken to maintain the person's health.

People's health conditions were identified in their care records. Staff told us they would seek medical

support if they were concerned about a person's health. A relative told us that the visit times were flexible, which enabled the person to attend health appointments. This meant people could be confident that appropriate medical advice would be sought as needed.

Is the service caring?

Our findings

People who used the service and relatives told us that the staff were caring. People had regular care staff and were very positive about them. One person told us that the care staff were "respectful and friendly." Another person told us that they were introduced to the care staff to make sure they were happy with them and spoke the person's first language, which was not English. This helped with communication.

A relative said, "Brilliant support that's made a difference to [person's name] life." Another relative praised the care staff that looked after their family member and said "they treat [family member] with dignity, they're [staff] like family, respectful and integrated."

People were provided with a folder which contained a copy of the service user guide and their care plan. There was also a range of information about the service including the care and support provided, how people's views would be sought, and how to report concerns or make a complaint and the contractual agreement. The registered manager told us they would provide the contact details for the local advocacy service or the social services department should they need support to raise issues.

People who used the service and some relatives we spoke with were involved in the planning of the care when they first started to use the service. One person told us that they wanted a female staff member who was able to converse in their family member's first language which was not English. Some staff employed by the service spoke a number of languages other than English which reflected the multi-cultural community. That helped ensure that people using the service were able to express their views about their care and support because communication was made easier. The daily wellbeing logs showed people made day to day decisions as to the meal prepared and the support provided to meet their personal care needs.

People told us that staff respected their privacy and dignity and understood that they were supporting people within their own homes. One person told us that they felt comfortable with the care staff because they understood and respected their cultural and diverse needs. A relative told us that their family member's privacy and dignity had been respected.

Staff we spoke with had a good understanding of people's needs and were able to tell us how they care for people in a dignified way. They were able to describe to us how they preserved people's privacy and dignity when providing personal care. One member of staff told us they encouraged people to do as much as possible for themselves and to maintain their independence without compromising their safety. This demonstrated that staff respected people's privacy and treated them in a dignified manner.

Is the service responsive?

Our findings

People's needs were assessed as part of the initial assessments process and a care plan developed to ensure the care needs and the support required were known. The care coordinator contacted people each week for the first month to make sure the care and support provided was appropriate and made changes at this stage if required. One relative told us that they were contacted but we found no record was kept in the office for any contact or discussions with people or their family members. This meant the people's needs may not be met in a responsive manner because the provider's system of record keeping was inadequate.

Care plans had basic information as to the care and support required by the person at each visit. There was some information as to people's preferences, cultural and diverse needs such as cultural diets to ensure staff were aware and respected the person's wishes. We found people did not always receive person centred care that was responsive. For instance, advice from a health care professional had not been acted on by the registered manager with regards to nail care for one person. Their plan of care had not been updated and the daily reports logs did not reflect the recommendations had been acted upon in order to maintain the person's health.

Care staff told us the care coordinator would inform them of any changes to people's care needs and they would read the care plans at each visit to be sure. However, we found a number of instances, whereby this was not the case. Recommendations made by the dietician were not acted on or communicated to the care staff to ensure one person was provided with suitable meals. Another person was cared for in bed and had been instructed not to use the hoist to transfer them as a suitable chair was not available but the care plan and risk assessment had not been updated. There was no record kept of communication with the care staff advising them of the changes to people's needs. This showed a lack of an effective system and record keeping. This meant the people were not at the centre of the care they received and the service was not always responsive which could affect their health and wellbeing.

We asked people who used the service and relatives we spoke with about their involvement in the review of their care plan. People's experiences of being involved in a formal review differed. They told us that the care coordinator would call them or would check they were satisfied with the service provided when they provided the care. The care coordinator conducted unannounced 'spot checks' on the care staff. At these visits people had the opportunity to share or raise concerns or report any changes to their needs. Even though some people had the opportunity to make comment about the service, it showed that the frequency and method by which people's views were sought was not consistent with the provider's policy.

We found accurate records such as risk assessments and care plans were not maintained. The registered manager told us that old care plans and risk assessments no longer relevant were shredded and no electronic records were kept. That meant personal and confidential information related to people's care was not retained in line with legal requirements.

The registered manager told us reviews took place every six months or when there were changes to the person's care needs or health. But we found no record was kept of the review meetings, actions as to the

changes needed and their view about the quality of service provided. For instance, one person's care started in March 2015 but there was no record that their care plan had been reviewed even though the daily wellbeing logs showed changes to their health. This also showed the provider's procedure to monitor and review people's care was not followed.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were introduced to the staff to ensure they were comfortable with them and provided the care and support they needed. One person said "They take good care of me and always on time, unless traffic" and felt the care staff supported them at a pace that suited them because they were at risk of falling. A relative told us that care staff knew their family member's preferred routine, and encouraged them to do as much for themselves as possible. This showed the service encouraged people to maintain their independence where possible.

People who used the service and relatives were confident that the registered manager would address concerns if they had any. One person said, "There's no complaints or faults with this agency." A relative told us that when they were unhappy with a member of staff that supported their family member the care coordinator acted quickly and identified another member of care staff to provide the support.

The service user guide provided to people made reference to a formal complaints procedure but the procedure was not included. The complaint procedure set out the process and contact details for the local authority and Care Quality Commission. Therefore, if people had to request a copy of the complaint procedure should they wish to make a complaint the service was not open and transparent and could deter people from making a complaint. The registered manager assured us that the complaints procedure would be provided to everyone who used the service along with the contact details for local advocacy services.

The complaints log showed that the service had not received any concerns or complaints. A relative told us concerns raised about a member of staff were addressed but no record was kept.

We, the Care Quality Commission referred the concerns received in October 2015 about inadequate staff recruitment procedures and staff training to the registered manager to investigate. Although the registered manager assured us at that time that robust staff recruitment and training was in place, during this inspection found evidence that this was not the case. This meant that people could not always be assured complaints would result in improvements to the service provided to protect people's safety and wellbeing. The registered manager assured us they would maintain a log of all complaints, concerns and the investigation outcome to assure people that the service is responsive to concerns.

The service had received compliments and thank you messages from the people who used the service and relatives about the care provided.

Is the service well-led?

Our findings

We asked people who used the service, their relatives and friends we spoke with whether their views about the care and support provided was sought. Most told us that someone from the office called to check whether they were satisfied with the service provided, but no record was kept of the feedback received.

The service had a registered manager in post. However, their leadership was not effective because the provider's policies and procedures were not fully implemented. We found the registered manager had not kept their knowledge and training up to date. For example, there were gaps in their understanding and responsibilities with regards to the safeguarding adults and MCA procedure. Confidential records relating to people's care and the care staff were destroyed.

The registered manager had limited experience of providing personal care support because they had not undertaken any training in moving and handling, risk assessment and person centred care. This training would enable the registered manager to provide care in the event staff absence at short notice and assess care staff's competency during spot checks, observe practices as part of staff supervision and the development of the service. Therefore, the reliance on the care coordinators experience in the service delivery was essential.

The service relied on needs assessment carried by the local authority that funds the care provided because the provider's documentation to assess risks were not adequate. Risk assessments carried out by the service was not robust therefore; the care plans did not always reflect the measures and the recommendations from health care professionals to ensure the person's health and wellbeing was maintained. People were not at the centre of the care provided or involved in the review of their care as those were ad hoc and no records kept. Care plans were not kept up to date to ensure the care staff knew what support people required.

The service did not maintain accurate and up to date records relating to the people who used the service. When we raised this with the registered manager they showed us a spreadsheet that listed when people who used the service were contacted as part of the review of their care or to seek their views about the service provided. There was no record of what was discussed, their views were about the service provided or changes or concerns because the actual notes from the conversation had been shredded.

The registered manager showed us a file which contained surveys completed by people using the service and staff. The responses were positive about the care provided. The survey results identified improvements were needed to the care plans, but it was unclear whether the improvements had been made as the old care plans were destroyed.

The registered manager did not understand the principles of good quality assurance even though the provider's governance policy and procedures set out the expectations and monitoring required. We found the quality assurance systems had not been fully implemented and fragmented where it had been implemented. The registered manager was unable to provide evidence of any effective monitoring system that highlighted risks and how these were managed. This meant that shortfalls could not be identified in

order to bring about improvements to the service. Clear and accurate records were not kept to enable the provider to monitor the delivery of care. For example, records were destroyed and not kept in line with the legal requirements.

We found effective systems were not in place to ensure staff were supported, supervised or received the training to ensure their knowledge and skills were kept up to date. Spot checks were carried out on the care staff using the provider's spot check form which assessed the care staff's presentation, conduct and timing and any feedback from people who used the service. We found no completed spot check forms in the staff files. The registered manager told us they shredded the information after any relevant information had been transferred to electronic records. We saw action was needed to improve the staff's presentation and conduct from a spot check visit. But there was no record of the action taken or the support provided to bring about improvements to ensure people received the best possible care from care staff. This meant that people who used the service could not be assured that provider's management of staff training and support was properly managed to ensure they received a safe quality service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>People's care was not being delivered in accordance with their assessed needs, preferences, treatment collaboratively with the relevant person and/or others care plan and did not ensure their safety. Assessment of people's needs and care plans were not person centred or reviewed regularly with the person or took account of other information including staff and health care professionals.</p> <p>Regulation 9(1)(a)(b)(c)(3)(b)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>The provider had not acted in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards by carrying out mental capacity assessments; made appropriate referrals, sought information in relation to best interest decisions made and kept those under review. Regulation 11</p>
Regulated activity	Regulation
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Providing care and treatment in a safe way. Assessing the risks to health and safety of people receiving care or treatment.</p> <p>The provider did not assess risk, monitor, and</p>

review the needs of people to ensure that the care provided was safe and new needs could be met. Care plans lacked guidance for staff to follow. Regulation 12(1)(2)(a)(b)

Regulated activity

Regulation

Personal care

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

The provider did not follow the recruitment procedures effectively to ensure persons employed were of good character, had the qualifications, skills and experiences and checks carried out to ensure they were suitable to work with vulnerable people. Regulation 19(1)(a)(b)(2)

Regulated activity

Regulation

Personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider did not ensure staff received appropriate support, training and professional development and supervisions to enable them to carry out their duties safely. Regulation 18(2)(a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who use the services and others were not protected against the risks associated with good governance because of inadequate systems and processes to assess, monitor, lack of contemporaneous and accurate record keeping and improve the quality and safety of the services provided. Regulation 17 (1) (2)(a)(b)(c)(d)(f)

The enforcement action we took:

Warning notice issued