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De Vere Care - Milton Keynes

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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This unannounced inspection took place on 20 and 22 September 2017. This service is a domiciliary care agency which supports people with their personal care needs in their own homes. At the time of our inspection 19 people were receiving care from De Vere Care – Milton Keynes.

There was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had failed to deploy sufficient numbers of staff in order to meet the needs of people who used the service and failed to demonstrate a systematic approach in determining the number of staff required. People were not always cared for by staff that had the knowledge, skills, experience and support they needed to carry out their roles. Staff did not receive appropriate supervision or training to enable them to fulfil their responsibilities.

The service had been without a registered manager in post for four months and this lack of leadership had significantly impacted on the quality of care that people had received. The provider did not appear to be aware of the seriousness of their lack of oversight of people's care and the significant risks this posed to the people relying upon the service for their care.

The systems in place monitoring planned care visits to people was inadequate. The service had a call monitoring system in place which could not be relied upon as an accurate reflection that people had received their planned care.

The provider did not have sufficient guidance for staff to follow to show how risks to people were mitigated and not all potential risks had been assessed.

There were not always appropriate arrangements in place for the management of medicines. There were occasions when people did not receive their prescribed medicines because the provider did not ensure there was enough adequately deployed staff to meet their needs.

There was poor monitoring of people's nutritional and hydration needs which put people at risk. Records could not be relied upon as an accurate account of people's food and fluid intake. There was lack of monitoring and oversight of people who were at risk of not eating or drinking enough.

The provider had not changed their practice in relation to issues raised in verbal complaints and actions had not been identified to prevent similar concerns being raised.

Providers are required by law to notify Care Quality Commission (CQC) of certain events in the service such

as serious injuries and safeguarding concerns. Notifications had not been reported to the CQC.

People were supported by staff who were aware of the requirements of the Mental Capacity Act 2005. People and relatives told us staff gave them choices.

Staff understood people's needs. However care plans were not up to date to support staff in delivering safe care and support in accordance with people's individual needs.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the end of the inspection the provider informed us that they intended to close the service De Vere Care – Milton Keynes. They told us that they would work closely with the local authority to ensure that packages of care and support were provided by alternative agencies. The Care Quality Commission have received a notification from the provider to cancel their registration for this location.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There was not enough staff adequately deployed to meet people's needs.
Some calls were missed and other people did not receive calls at the times they needed.

Risk assessments did not always include guidelines for staff to mitigate known risks to people. Risk assessments were not always in place for risks that had been identified.

There were not always appropriate arrangements in place for the management of medicines.

Safe recruitment practices were in place.

Is the service effective?

Inadequate

The service was not always effective.

People did not always receive appropriate nutrition and hydration to ensure their health and wellbeing.

The provider did not have effective systems in place to ensure that care staff had the appropriate knowledge and skills to support people with their care needs.

People were supported by staff that were aware of the requirements of the Mental Capacity Act 2005. People told us staff gave them choices.

Is the service caring?

Requires Improvement

The service was not always caring.

The registered provider did not always take action to ensure that people felt supported and valued.

People's values and beliefs were considered and reflected in their care plans.

People enjoyed a positive relationship with their regular care staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff understood people's needs. However care plans were not up to date to support staff in delivering safe care and support in accordance with people's individual needs.

The provider had not changed their practice in relation to issues raised in verbal complaints and actions had not been identified to prevent similar concerns being raised.

Is the service well-led?

Inadequate

The service was not well-led.

There was not a registered manager in post.

Providers are required by law to notify CQC of certain events in the service such as serious injuries and safeguarding concerns. Notifications had been reported to the CQC.

The service did not operate effective systems to assess, monitor and improve the quality of the service provided.

De Vere Care - Milton Keynes

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 20 and 22 September 2017 and was unannounced. The inspection was completed by four inspectors and one expert by experience that made telephone calls to people who use the service, their relatives and staff. An expert by experience is a person who has personal experience of using a service like this, or has experience of caring for someone who uses a service like this.

This inspection was completed in response to concerns we had received and therefore we did not ask the provider to complete a Provider Information Return (PIR). 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.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification provides information about important events which the provider is required to send us by law. We also contacted health and social care commissioners who place and monitor the care of people living in the home to identify if they had any information which may support our inspection.

During our inspection we spoke with six people who used the service, five relatives, eight members of care staff, the Care Coordinator and representatives of the provider.

We looked at care plan documentation relating to seven people, and five staff files. We also looked at other information related to the running of and the quality of the service. This included quality assurance audits, training information for care staff, staff duty rotas, meeting minutes and arrangements for managing

complaints.

Inadequate

Is the service safe?

Our findings

There were not enough staff to keep people safe and to meet their needs. One person told us "Sometimes no one turns up to help me and I just have to try and sort myself out; I can't wash myself so I have to go without." Another person told us, "When my carer hasn't turned up I miss my breakfast because I can't get it myself; I haven't gone to the day centre that I like going to because my carer didn't turn up to help me get washed and dressed." One relative told us "[Person] missed four calls in a row; it just isn't good enough." We saw, and people, their relatives and care staff told us that there had been numerous occasions in the past four months when De Vere Care had been unable to provide the care and support to people that they had been contracted to provide. One member of care staff told us "I am not proud to be working for the agency; I feel terrible for clients when I go in the morning to deliver their care to be told by them that no one turned up the evening before to give them their tablets and help them to bed."

There were some occasions when De Vere Care had anticipated that they would not be able to deliver care to people, and relatives had been contacted to ascertain if they could support their loved one. One relative told us "At least they [De Vere Care] let me know they couldn't cover [relatives] call; but to be honest it is getting too frequent." This relative went on to tell us "I have lost all confidence in the agency; I get that dreaded anticipation feeling when the phone rings thinking they are going to tell me they can't do the care this weekend; it can't continue." Another relative told us "[Person] has a live in carer and it all works great until the carer has their week break. I make contact with the office to see who is covering and they can't tell you." This relative went on to tell us that sometimes the agency did find cover but it is a member of care staff who the person doesn't know and on one occasion the agency were not able to provide any cover and the person had to be cared for by the relative.

People could not be assured that the care staff would arrive at the agreed time. People told us that they could not rely on care staff to arrive on time to support them with their personal care, meals and food preparation and medicine. One person told us "I never used to have any problems but the past few months haven't been good at all. My carer should come in the early evening for my last call but the office telephoned me to say they couldn't get anyone until 11pm. I told them to cancel the call and I asked my family to help me." Another person told us, "The carer's are often late; sometimes two hours late; it makes me anxious." One relative told us, "[Person] gets really anxious before every care call, they sit and clock watch and are worried no one is going to turn up. Most of the time [person] doesn't receive a telephone call to say the carers will be late; communication is awful."

We reviewed the rotas and we saw that whilst care had been planned effectively there was not enough staff to deliver care in a timely manner if other members of staff became unavailable for work, which had occurred on a number of occasions. The service did not regularly review their staffing to ensure they could respond to people's needs. This had resulted in the service contacting the local authority, often at short notice, to state they could not provide the care they had been commissioned to complete. We saw that the service had attempted to recruit new staff however this was not in a timely way to ensure they could meet the needs of the people they were already supporting.

The systems in place monitoring planned care visits to people were inadequate. The service had a call monitoring system in place which if used effectively would have been able to identify that people had not received their planned visits. However, less than half of the care staff used the call monitoring system which meant that the system was not effective. We spoke to the care co-ordinator about the call monitoring system and they explained that some care staff forgot to log in to the system when they arrived at people's houses to deliver care, some staff did log in but forgot to log out, and some staff didn't use it at all. There was also some people using the service who did not wish to have the call log system used in their home; however there was no evidence of this or any other system in place in effectively monitor if people had received their calls. We viewed the call log system on the day of our inspection and noted that over 50% of planned visits to people had not been logged on to the system. We asked the care co-ordinator how they could be assured that people had received their care calls and they told us "No one has called us to say they haven't received a call."

The provider had failed to ensure that staff were deployed adequately. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had risk assessments in place however they were not always complete and not always followed due to the lack of adequately deployed care staff. Areas of people's care that had been identified as a risk did not always have appropriate guidance in place to help direct staff to provide safe care. For example, we saw that one person had been identified as at risk of neglecting their nutritional needs. We saw that staff were scheduled to visit at lunchtime however the risk assessment did not provide any guidance about how to encourage the person to manage their nutrition, or what action they should take if there were concerns. One member of staff told us that this person did not drink enough and whilst they offered the person a variety of drinks there were no risk assessments in place if the person failed to drink enough. We saw that another person had been identified as being at risk of falls however there was no action plan to minimise or reduce these risks. One member of care staff told us "[Person] fell out of bed the first time I was caring for them. Nobody showed me how to position [Person] safely and there was no risk assessment or information in the care plan. I had to call an ambulance and the relatives; in fact it was the relatives who showed me how to position the person correctly."

The provider did not support staff in following people's plans of care that were in place to reduce the known risks to people For example: One person who required two care staff to assist with changing position, had on occasions been supported by only one staff member. The care staff told us "When the second carer doesn't turn up what can I do? I have to complete the care on my own and do it as safely as I can but it isn't ideal. When I have contacted the office they have just apologised and said they couldn't get another member of staff." We viewed this person's daily care chart and saw that there had been five occasions in a four week period when a second carer wasn't available to support with moving and handling. Another care staff told us "[Person] is at risk of slipping out the shower chair so I have to be really quick when helping them to shower because I am so frightened they will slip off the chair; I have told the office about this but I haven't heard anything back." This member of staff went on to tell us that there was no risk assessment in place for supporting this person to shower and no information in the person's file about the risks that had been identified. People were at risk of harm because appropriate risk management systems and processes were not in place and followed.

The provider did not have sufficient guidance for staff to follow to show how risks to people were mitigated and not all potential risks had been assessed.

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

People were not always protected from the risk of unsafe care and harm because the provider failed to ensure that safeguarding incidents were reported appropriately to the local authority and to the Care Quality Commission [CQC]. Between the period of May 2017 and September 2017 the provider was aware of multiple missed calls to people using the service resulting in people not receiving personal care, missed food and fluids and on occasions medicines. Unsafe care practice was undertaken on at least five occasions where only one member of staff supported a person with moving and handling tasks when the person required two staff. The provider had notified the local authority of some of these safeguarding alerts but had not informed the CQC as per the statutory requirements.

The service had satisfactory policies and procedures in place to protect people from abuse, however these were not followed. Staff had received training in safeguarding but some staff were out of date on their refresher training which meant they may not have been up to date with current best practice guidelines. Staff were able to demonstrate that they knew the different signs and symptoms of abuse and said they were confident about how to report any concerns they might have; this was also evidenced by contact that had been made to CQC by care staff raising their concerns about neglectful care and staffing levels.

The lack of oversight by the provider in the absence of a registered manager contributed to repeated occasions of neglect, and lack of support for the care co-ordinator. This resulted in neglectful care and support not being investigated and people continued to receive care that was unacceptable. One relative told us "They [De Vere Care] know about the missed calls to [person], sometimes we receive an apology from the staff in the office but then it happens again. I am not asking for them to be perfect but this shows me that those in charge do not care and they are not doing anything to change it."

The registered provider lacked knowledge and oversight of the safety of the service and was not safeguarding people who used the service from neglect.

This is a breach of Regulation 13 (1), (2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always appropriate arrangements in place for the management of medicines. Some people, relatives and care staff told us about occasions where medicines had not been administered due to the missed calls from care staff. One relative told us "[Person] only has eye drops so it isn't too much of an issue when they haven't been given; but if it was other medication that would have been missed as well because the care staff didn't arrive." One member of care staff told us "Last month I noticed someone had not had an evening call; they hadn't received their tablets. I reported this to the office." Another relative told us "I have on a number of occasions had to drive over to [Person's] house to make sure they have had their tablets because the office has telephoned and said they couldn't find a carer for the call. It isn't good enough."

People also told us that when care staff did arrive for their planned calls there wasn't normally an issue with medicine. One person said "I always get my tablets on time; the staff are really good like that." Another person who had live-in carers told us, "No problems with my medication, I always have them." One care staff told us "I make it my place to know about all the medicines that people are taking; I've had medication training."

Staff told us and records confirmed that care staff had training on the management of medicines and throughout the year they received competency assessments to ensure they were administering medicines safely. However, we noted that there had been no competency assessments of staff since April 2017 and that some staff were out of date on the medication refresher training.

Environmental risk assessments were in place for peoples' homes to inform staff how to stay safe. For example, if there were any steps to negotiate, the lighting and location of utility points such as stopcocks for turning off water.

Safe recruitment processes were in place to protect people from the risks associated with the appointment of new staff. We saw that references had been obtained for new staff prior to them working in the service as well as checks with the Disclosure Barring Service (DBS). This helped ensure that only staff of a suitable character was employed to provide people's care.

Inadequate

Is the service effective?

Our findings

People and their relatives had mixed views about the skills of staff providing care. One person told us "I use a hoist to help me move from my bed and I am not confident that new staff know how to use it." A relative told us "It varies between the staff, some are well trained and others don't seem to be quite as knowledgeable as I would like. It isn't always a problem if they ask because [Person] can tell them their needs." Another relative said "The regular carer is brilliant, no concerns at all, they know [Person's] care really well and they are trained in [Person's] specific condition which is really reassuring. However, when the main carer has her time off we have had staff who don't always know what they are doing."

We also received mixed views from care staff about their own training. Some care staff told us that they had received adequate training and specific to people's needs. For example: One care staff told us "I have had some really good training especially when people have certain conditions. I have had catheter care, dementia care, Percutaneous Endoscopic Gastrostomy (PEG) (This is when a person receives food and fluid through a tube straight into the stomach)." Another member of staff said "I have had all of my training and all my refresher training at the beginning of the year." However, another staff member told us "I haven't received any refresher in the last 12 months at all, I keep asking but it isn't forthcoming." Another staff member told us "I care for people with dementia but I haven't received any training." Another member of care staff told us "I hadn't received any training on moving and handling when I first started the job and had to rely on other staff and people's relatives to show me what to do."

We viewed a number of training records and noted that some care staff were up to date and had received comprehensive training, while other staff were out of date on numerous courses, including moving and handling, medicine administration, emergency first aid, safeguarding adults and fire safety.

People were not always supported by care staff who received supervision and support to carry out their role. Feedback from care staff was varied in relation to the level of support they received. One care staff said "I have had two supervisions in the last year and these have been really rushed and I was given no time to prepare. I went in to the office to pick something up and was asked to stop for supervision; I felt pressured to stay." Another care staff said "I used to have regular supervision but I don't anymore; things have gone really downhill." A third member of staff told us "I have had regular supervision, I had one last week."

The majority of care staff told us that they felt supported by the care co-ordinator who was based at the office but they didn't feel supported by the provider. One member of staff said "It is a joke, how can I feel supported when we get no communication, no supervision and all of my training is out of date." Another member of staff told us "I feel supported by [care co-ordinator], they try to support all of us but they don't get any support from management." Another member of staff told us "This used to be a good place to work, but we have no manager and no monitoring officer and the staff member in the office is rushed off their feet all of time so I try not to bother them."

The provider did not have effective systems in place to ensure that care staff had the appropriate support, knowledge and skills to support people with their care needs. In the absence of a registered manager the

care co-ordinator and temporary managers that covered the service on occasional days did not have access to the staff training records and were therefore unable to monitor when staff required refresher training. This put people at risk of receiving care from staff that did not always receive appropriate training to enable them to carry out their duties effectively.

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

People's nutritional needs were not always managed effectively. One relative told us "[Person] has been admitted to hospital for severe dehydration, the staff do not give her a healthy diet; I purchased some vegetables but they are still in the freezer a year later." The same person also told us "Since the hospital admission the carers do leave a drink for [Person] when they leave now so things have got better. We saw that people's care plans highlighted the support some people needed to have their nutritional needs met however, the service failed to maintain adequate oversight of this. For example, one person's care plan identified that the person had a poor appetite but there was a lack of oversight to ensure that they had eaten adequately on a regular basis. Another person's care plan identified that they required full staff support to eat their meals. The care plan stated that they required a soft diet and that all food and fluid should be recorded. However, there was no oversight to monitor what the person had consumed, and no food or fluid charts were returned to the office to review. We spoke with one member of staff about this and they were unaware of when they should be concerned if the person had eaten minimal amounts.

People also missed meals and drinks when there was staff unavailable to deliver their care and support needs. One person told us "I've missed having my breakfast on a few occasions because the carers didn't arrive to help me. It is a long time to wait from my evening meal the day before until lunch time the next day. It doesn't happen often but it has happened recently." One relative told us "They [De Vere Care] forgot to roster a care staff to see [person], they had no food or drink and I wasn't able to get to her either. I have no confidence in them anymore."

There was a risk of poor nutritional and fluid intake because there was no effective monitoring of food and fluid and no guidelines for staff to follow in the event that a person had not eaten or drank enough when people were assessed as requiring support in this area.

Care staff who commenced employment with De Vere Care received an induction which included shadowing more experienced members of staff. At the time of our inspection the service had recently employed four new care staff and they were waiting for recruitment checks to be finalised before they could commence supporting people with their care needs. However; there was a risk that new staff would not have an accurate overview of people's care and support needs because care plans and supporting documents were not up to date and did not accurately reflect the care people required.

People were supported to access health services. People gave us examples of health professionals such as GPs and district nurses being contacted by staff on their behalf when they requested it. One member of staff told us how they had referred a person to the speech and language therapy team [SALT] because of difficulties with swallowing and a full assessment and guidelines were put in place by the SALT team which staff now follow. Another member of staff told us about occasions where the GP had been contacted because they were concerned about a person's ill health. Daily care notes we viewed contained information about people's health appointments and any changes to medicine.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack capacity to do so for themselves. The Act requires that as far as possible people make

their own decision 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. The application procedure for domiciliary care services is called the Court of Protection. We checked that the service was working within the principles of the MCA and found that they were. People's mental capacity was assessed when they began to use the service, and when people required support with this, their advocates were involved in making best interest decisions for people. We saw in people's care plans that people and /or their relatives had signed to give consent to personal care and support.

People told us that care staff sought their consent to care before undertaking tasks with them. One person told us "They always ask is it okay if they can do something, they are really good like that." A relative told us "The care staff themselves are really good, I can't complain how they treat [relative]; in fact they have a great relationship with them and I often hear them ask if they agree to things being done." When we visited a person in their home we observed care staff seeking consent from the person at all opportunities. For example: If it was okay to put a blanket over a person and whether it was okay to apply some hand cream to the person's hand.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us that individual staff members had a caring approach. One person told us "On the whole I have to say the carers are normally really nice, I get an odd one here and there that I am not happy with but generally they are good." One person's family member told us, "The regular carer is very caring; they have a great relationship with [person]." Another relative told us "If I put aside my disappointment with the missed calls I am actually happy with the carers that do come. They are lovely girls [staff] and they do everything they can."

However, relatives also told us that they didn't think the provider was very caring. One relative told us "I don't think those that manage the company are very caring; how can they allow these missed calls to happen time and time again. Why are they not doing anything about it?" Another relative told us "I don't have any confidence in them anymore, it isn't the care staff's fault it's those above them." Another family member said "How can they be caring when they miss calls and [person] has to put themselves to bed and not have a meal."

People and their relatives told us that most of the time their privacy and dignity was respected. Staff told us that they always closed people's doors and shut their curtains when they were assisting people with their personal care. One person told us "They are very good with that, they cover my top half while my bottom half gets washed." Another person told us "I have no complaints; I am always treated with respect by the carers." One member of staff said, "I always like to care for people how I would care for one of my relatives; and that is with compassion, dignity and respect. It is so important." However, when people had not received their planned calls they told us they did not feel that their dignity was respected. One person told us "When I have had to manage myself because the carer didn't turn up; there was nothing dignified in that." One relative told us, "I don't think I was respected when I should have had help to wash and dress at 10am and the carer didn't arrive until 2pm. All that time I had to wait in my pyjamas."

People were supported by staff who had a good knowledge and understanding about the people they cared for. The staff showed a good understanding of people's needs and they were able to tell us about each person's individual choices and preferences. Most people saw a regular carer and they had developed positive relationships with each other. Staff were able to tell us about people's likes and dislikes, and how they liked their care. One member of staff said "It is really important to know someone's routine and how they like to be supported." Another member of staff said "We have to be fully aware of the involuntary movements [person] can make so they don't injure themselves or us."

People's values and beliefs were considered and reflected in their care plans. We saw that when people had a preference not to discuss their values with staff this was documented in their care plans and staff were aware of the need to respect their wishes.

People were encouraged and supported to have choices and express an opinion, for example about what clothes they would like to wear or what food they would like to eat. One person told us "The staff offer me choices for my breakfast and other meals". One member of staff said, "I do what I can to help people decide

what they want. I get clothes out the wardrobe and show them a few ideas. I know what things most people like, and I go on what they say or do so they are comfortable."

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us that they had raised concerns about the support they or their loved ones had received. None of them felt they had received a full response or that a satisfactory outcome had been achieved.

The majority of the concerns that people and their relatives had raised were in relation to the missed care calls. One person said "Communication is terrible, it is always me contacting them to find out what is happening; it should be the other way around. They know I am not happy when they can't provide a carer for me but I don't think they write it down as a complaint." One relative said "It just isn't good enough; I received an apology from the office staff but haven't received anything else and it obviously doesn't change anything because the missed calls have continued." Another relative said "I have given up complaining because there is no manager to take responsibility so the errors keep on happening. We are looking for a new care company." Another relative said "I don't know if you would call it a complaint but I have told the office that we are not happy; [Person] and I are on edge all of the time; worried that a carer won't turn up. Things never used to be like this, we were really happy with everything; in fact I would have recommended De Vere Care six months ago, but definitely not now."

The temporary manager who was at De Vere Care on the day of the inspection was unfamiliar with the service. They were not able to tell us if any complaints had been recorded or investigated because they were unable to access the system where complaints may have been stored. It was evident from people and their relatives that satisfactory responses had not been received from their concerns raised. The provider had a comprehensive complaints policy and procedure in place, however they failed to ensure the processes were followed and failed to establish and operate an effective system for identifying, recording, handling, investigating and responding to complaints.

This was a breach of Regulation 16 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care and support needs were assessed before they began to use the service. People had care plans in place which provided an insight into their care needs and gave some guidance for staff. However the care plans were not reviewed or updated on a regular basis. We found that in the absence of a registered manager there was no staff member responsible for updating the care plans and as a result the care plans contained out of date information. One relative told us "They [De Vere Care] used to be really good at coming out and talking to me and [person] and updating the care plan; it doesn't happen anymore." One member of staff told us they didn't really use the care plans and any changes were communicated by a phone message. Another member of staff told us, "If I have to go to a new client I telephone the office to find out what care they need; the care plan cannot be relied upon to be accurate."

One care plan we viewed contained information that was out of date and no longer reflected the person's needs and current circumstances. For example: The care plan stated this person required the use of a hoist to manoeuvre from the bed to the chair; however the person and care staff supporting them confirmed the

hoist was no longer used because it could no longer meet the person's needs and a new ceiling hoist had been ordered. The care plan also advises care staff to be mindful about the person's dog; however the dog had not lived at the property for over twelve months. The care plan also stated that a second carer from another agency provided additional care four times a day to assist with moving and handling tasks; however, this is no longer applicable because the second carer was also a carer from De Vere Care.

All of the care plans we looked at contained omissions or inaccuracies, either because initial assessments had lacked detail or because people's care needs had changed.

People's wishes were identified in their care plans and this was respected by staff. For example: One person wanted female carers and we saw this request happened in practice. This person told us "I told the lady that came out to see me I didn't want a male carer and they have stayed true to their word; I only ever have the girls come to care for me." Another person requested a member of staff who could speak their first language. This person's relative told us "[Person's] main carer speaks the same language and this is so important as [person] has had a stroke and needs someone who can communicate with her."

Inadequate

Is the service well-led?

Our findings

The service had been without a registered manager for four months. We were informed by the provider that a manager had been appointed to the role and would commence at the service at the beginning of October 2017. However; we were informed at the end of the inspection that this was no longer happening and the proposed manager had declined to take the offer of employment.

The registered provider had failed to implement effective governance systems or processes and had not effectively assessed, monitored or driven improvement in the quality and safety of the care being provided at the service. We were unable to view any governance systems because the temporary manager that was present on the day of the inspection was not able to gain access to the information for this location.

The provider produced an action plan in September 2017 for the local authority. This set out their plans to address the immediate concerns in relation to the how the provider was going to ensure that people received the care they had been assessed for and the future plans for the service. However, the action plan failed to set out how the provider could offer assurances that people who used the service would receive their planned care and what contingency plans were in place to ensure that people would receive their planned care in the event of staff absences.

It was evident that the absence of a registered manager had resulted in a break down in the operational and managerial infrastructure and oversight of the service. Staff absence was high and there was no capacity in the staff team to cover for the absences which resulted in missed calls to people and staff undertaking unsafe care practices putting people at risk. Risk management and risk mitigation systems and processes were not being utilised in day to day practice and people were being exposed to unacceptable and unnecessary levels of risk and harm. Risks to people had not been appropriately assessed, monitored, reported or recorded and the risk of reoccurrence was high.

The culture of the service was poor. There was a lack of oversight and consistent leadership which resulted in people receiving care and support which was inadequate. People could not be assured that their assessed needs would be met. People sometimes went without the care and support they required, they didn't always receive medicines and adequate food and drink including monitoring of foods and fluids where people were identified at nutritional risk. Risks were not always assessed or identified and people were at risk of unsafe care. The provider was aware of these omissions in care delivery and failed to take timely and appropriate action to immediately address the failings.

Staff were not receiving the supervision, direction or structure that they required to provide good care and many of the staff told us they were unhappy and discontented with the way in which the service was being managed. Although they felt supported by their colleagues they were consistent in their view that the senior management of the service was not listening or taking their concerns seriously. All grades of staff were working under a great deal of pressure and there was no evidence that the adequacy of the staffing levels had been considered based on the needs and dependency levels of people currently using the service. This was having a direct impact on the adequacy of the care provided to people and was fundamental to many

of the regulatory failings identified at this inspection. Despite this the provider continued to seek and accept new packages of care.

Staff, people using the service and their relatives talked about the lack of managerial stability, the impact on staff turnover and the lack of coordinated and safe care. One relative told us, "It is beyond belief that they cannot find the staff to deliver the care to [Person]; why are those in senior management roles not doing anything about it." One member of staff told us, "The communication is terrible from seniors managers; we have just been left to get on with it. The pressure to pick up extra hours is never ending but I have to have to time off as well." People felt that there was no focal point in terms of raising concerns. One relative told us, "There is just [staff member] in the office, there isn't anyone else. I am angry about the missed calls but I don't blame [staff member] for that, they are doing the best they can with no support from any management."

Records relating to people's care and treatment were not up to date and did not reflect people's current care needs. In the seven people's care records were viewed, we saw that all of these records did not contain the most up to date information and had not been reviewed. One member of care staff told us, "If I was visiting someone new I wouldn't read the care plan; they are so out of date." We were informed that updating care plans was the role of a monitoring officer; and there wasn't a monitoring officer currently in position at this service.

Staff meetings were not planned and staff told us they could not remember when the last meeting was. Two staff told us that previously when staff meetings had been organised they didn't attend them because they were scheduled for their rest breaks. One member of staff told us, "I think there was a meeting recently but I wasn't able to attend and there were no minutes to read afterwards." Minutes of staff meetings were not available upon our request. This compounded the feeling amongst staff that they were not supported or communicated with by the senior management of the provider.

The provider had failed to ensure that there were clear lines of responsibility and accountability at all levels. In the absence of a registered manager the provider had provided temporary management cover at the location. However; the management cover was provided by different managers with in the company which provided no consistent leadership and temporary managers did not have access to the oversight of the service. For example, temporary managers were unable to access the records of complaints that the service had received.

Verbal complaints that were received by the service were not recorded and investigated as complaints. An apology was given to people and their relatives by the member of staff who was office based but there was not an effective system in place for investigating the concerns raised and for lessons learnt to be embedded into the culture of the service. It was evident from people and their relatives that satisfactory responses had not been received and the provider had failed to establish and operate an effective system for identifying, recording, handling, investigating and responding to complaints.

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

There was evidence to show that where reportable incidents such as missed calls had occurred that these had not always been reported to CQC. We were informed by the local authority of numerous occasions where people had not received a planned to call to support them with their personal care. During our inspection we were informed about the missed calls by people, their relatives and the staff team. People told us about occasions where they had to attempt to put themselves to bed because no care staff turned

up. Other people told us how they went without meals and without having a wash because no care staff turned up. Relatives told us about occasions when they had been contacted by De Vere Care to inform them they could not visit their relative as planned and that relatives were required to provide the support. Staff told us and records evidenced at least 5 occasions where two staff were required to support a person and because of staffing availability only one person carried out the task. CQC had not been informed of any of these occasions where people were at risk of neglect.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4)