Roses Socialcare Ltd

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Inspection report

Burntwood Community Centre
Church Mount
South Kirkby
West Yorkshire
WF9 3QS

Tel: 01977652663
Website: www.rosessocialcare.co.uk

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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

The inspection took place 6 and 12 May 2016 and was unannounced. We returned to Roses Socialcare Limited 9 June 2016 to check whether actions the registered provider had told us would be undertaken by that date had been completed. We found there was very little evidence of improvement and the actions which had been completed were not to the required standard. There was a registered manager, but they were on a leave of absence and were not present during the inspection in May however they were present during our visit 9 June 2016. There was a manager who was responsible for the day to day operation of the service; however they were only present during the later afternoon of the inspection.

Roses Social Care is a domiciliary care agency who provides care and support to people in their own homes. The people who were being supported had a range of needs including living with dementia, terminal illness and older people who required support to remain independent in their homes. At the time of this inspection 23 people were receiving care and support from Roses Social Care.
The service was previously inspected in October 2015, at this time the service was found to be requiring improvement and there were breaches identified in relation to person centred care, need for consent and good governance. At this inspection we found there had been a significant deterioration of the quality and safety of the service.

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.

Staff demonstrated a basic understanding of the principles of protecting vulnerable people and keeping them safe. Staff were able to tell us who they would report concerns to and describe the types of abuse they would look out for.

There were very few risk assessments in place. Those which were in place were not risk specific and did not show what the risks were and what measures needed to be in place to minimise those risks and promote people's safety.

There were no records available to demonstrate the registered provider recorded accidents and incidents, therefore there was no evidence these matters were investigated and 'lessons learnt' taken from them where appropriate.

Staff recruitment was disorganised and we found the processes which were in place were not followed which led to unsafe recruitment practices. These included not seeking references from previous employers, not gaining a full employment history including accounting for gaps in employment, and we found instances where a person had been allowed to work before their disclosure and barring service (DBS) check had been received and other instances where staff had failed to disclose criminal convictions on their applications

which showed on their DBS checks. These staff had been allowed to continue working without any risk assessments and there was no evidence investigations had been carried out into their dishonesty during the recruitment process.

Staff were not adequately trained or skilled to carry out their roles. This was particularly in relation to the use of equipment to assist people who were unable to move themselves without this. There was no evidence that appraisals were carried out and there had been no recent supervision of staff. Quality checks were not carried out regularly to observe the practice of staff working with people in their own homes.

There were not sufficient staff to safely meet the needs of people who used the service. This had led to missed and late calls.

There was clear evidence of instances where family carers had been asked to help to use equipment because only one care staff was available for a call which required two care staff.

There were instances where missed and late calls had not been appropriately reported or investigated, to the relevant authorities. This meant there was no learning from the issues which had led to the calls to be missed.

The information in care plans was unclear and conflicting about the level of assistance people required to take their medicines safely. There was evidence staff were assisting people to take medicines when there was no evidence to support they should be giving this support. There were no processes in place for medication administration records to be brought into the office and checked to identify any errors or issues with prescribed medicines.

There was no evidence that people had been asked for or had given their consent to the care which was being given. There were also no mental capacity assessments in place to show whether people had capacity to make their own decisions about their care or whether they needed this to be carried out in their best interests.

Care plans were not in place for all the people who used the service in the office. There were some cases where there were summary care plans in place which were short task based summaries of what should be carried out during each planned visit. These were not adequate to meet people's needs and were not reviewed to reflect changes to people's needs.

There had been no complaints recorded since our last inspection, despite people who used the service telling us they had raised complaints and concerns with the office team.

There was no leadership evident in the service. The manager who was in post told us they spent a significant amount of their time carrying out care calls as there were not enough staff to cover them. This meant there was no management presence and no contact with the manager whilst they were delivering care to people who used the service.

There were no processes or systems in place to monitor the quality and safety of the service. There was no oversight available to the registered provider to be able to judge the service was being well run and the quality and safety of people was assured.

In total we found breaches of eight Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 had been late calls, missed calls and calls where only one member of staff arrived when there needed to be two.

There were very few risk assessments in place and these were not risk specific and did not show the measures which needed to be in place to keep people safe.

It was unclear from care plans what level of medicine administration was required and people's medication administration records (MARs) were not regularly brought to the office and checked for accuracy.

Is the service effective?

Inadequate

The service was not effective.

The provider could not evidence that staff were trained to the appropriate standard as there was no training matrix and certificates were not filed.

There was no evidence staff at the service was considering or assessing the mental capacity of the people who used the service. Care plans were unsigned with no evidence consent to care had been obtained.

There had been very few supervision, quality checks or appraisals carried out which meant staff were not being appropriately supported in their roles.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us staff were kind and caring during their visits.

There had been issues with staff not respecting people's confidentiality.

There was no reference to people's cultural or religious needs in

any of the records we reviewed

Is the service responsive?

Inadequate

The service was not responsive.

There were summary care plans in place in some of the records we looked at but in some files there were no care plans evident.

There was no evidence that people's care needs were regularly reviewed to ensure their needs were met.

There were no complaints recorded despite the level of dissatisfaction we found in both people who used the service and staff.

Is the service well-led?

Inadequate

The service was not well-led.

There were no auditing processes in place to monitor and assess the quality and safety of the service.

There was no clear leadership in the office during the inspection and the office was left unmanned for several occasions during the day.

The quality of the records was poor and there were no systems in place for regular checks of the records which were stored in people's homes. Daily records were not brought into the office for auditing regularly.

Roses Socialcare Ltd

Detailed findings

Background to this inspection

We undertook an unannounced inspection of Roses Socialcare Ltd on 6 and 12 May 2016. This inspection was undertaken to ensure the concerns we had at our previous inspection had been addressed. We returned to Roses Socialcare Limited 9 June 2016 to see whether the actions which had been identified by the registered provider had been taken in line with the action plan they sent to us following our concerns.

The inspection team consisted of two adult social care inspectors. During our inspection we spoke with four people who used the service and their families, two members of care staff and the registered manager. Prior to our inspection we had received information of significant concern from a number of whistle blowers. This was in relation to concerns about the recruitment process which was in place and care calls being missed. There were also concerns raised about the standard of the training some care staff had received before they began work. The service was last inspected in October 2015, and was found to require improvement in safe, effective, responsive and well-led. At this time there were three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with other agencies who worked with the service to gather further information; these included local authority social work teams.

During our inspection we looked at the care records of 11 people who used the service. We visited the homes of four of the people whose care records we had sampled. We looked at the staff files for 19 staff and a variety of other records including, complaints and concerns, safeguarding, policies and procedures and auditing of the service.

Inadequate

Is the service safe?

Our findings

People who used the service told us, "I have had missed calls, the biggest problem though is them being late and not letting me know." Another person told us, "There have been times when I have had to call the office as only one carer has turned up and they can't care for me on their own I need two carers."

Staff we spoke with had a basic understanding of safeguarding vulnerable people. We asked staff about the organisation's whistle blowing policy and staff were unclear as to what this was. One member of staff thought this was in relation to loud noises and people not liking them. It is important that staff understand the whistle blowing policy so they can report their concerns without fear of recrimination.

We looked at the recruitment files for 19 staff. In every file we reviewed there were sections which had not been fully completed or were blank. These included employee verification forms, shortlist summary and interview records. We had received information of concern in relation to there not being appropriate pre-employment checks carried out before care staff commenced working with vulnerable adults. We reviewed the records for disclosure and barring (DBS) checks and pre-employment references.
We found there was an instance where a member of staff had been allowed to accompany other staff in to people's homes as part of their training; this was before their DBS check had been received. Records showed the member of staff had a conviction which they had failed to disclose in their application. There was another instance where a member of staff had a recent conviction which they had failed to disclose and they were employed without any action being taken or any risk assessment being carried out. We also identified during our inspection there had been a member of staff who had continued to work without a valid visa to do so. The registered manager was aware of the situation as we had raised that the visa was about to expire at our last inspection.

We reviewed the references which were in the files we looked at. We found in five of the 19 cases there were references which had been supplied by friends, or the referee was not listed in the person's application form as a previous employer. We found in 15 of the 19 files there were only one reference received, and there were two files where people had declared significant health concerns which could put people at risk and there were no risk assessments in place for these.

We were concerned we could not find recruitment files for all staff. We therefore asked for a current list of staff and compared the names to the files which were present in the office. We found there were 13 names where there were no staff files, four staff files for people who were not on the current staff list and one case where there were two files for the same person, however one of them was full of a mixture of records relating to other staff, none of which related to the name on the file.

This meant the registered provider did not have a recruitment process which ensured adequate pre-employment checks were carried out prior to staff being employed. This meant vulnerable people were being put at risk of harm. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the manager about current staff levels for the service. The manager told us they were understaffed at present and needed to recruit five staff to achieve adequate staffing for the service which was currently being delivered. There was recruitment activity taking place, however the recruitment officer was leaving on the day of inspection and, whilst there was a replacement identified, there would be a period of transition which could delay the processes. Staff we spoke with told us, "There are never enough staff. Staff have gone. We are always asked to do extra hours."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as there was not sufficient staff to meet people's needs consistently and in a timely manner.

People who used the service told us, "Sometimes only one (care staff) turns up; I have to ring the office to get another. One can't deal with me." Another person told us, "A couple of times at the weekend we haven't had anyone come." A relative of a person who used the service told us, "[Name of person] has a hoist, we have never used it, we lift [name of person] out. One carer won't do it, but the rest do." Another relative told us, "They have missed once or twice, the biggest problem though is [care staff] being late, especially if I have arranged to go out." A third relative told us, "They have asked me to be the second carer, and I have done it. My son said this had to stop as I might hurt myself. There was one time a carer came who didn't know how to use the equipment, so I trained them myself."

We looked at the daily records of some of the people who used the service, as we had received information of concern relating to people not receiving their care calls and one member of staff arriving to carry out a two person care call. We looked at the records for one person who required two care staff at each visit and found there had been six occasions when only one care staff had signed the daily record sheet (two of which recorded in the body of the content that only one care staff was present). This was within a period of five weeks and had occurred since the last inspection.

This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014, because the registered provider was not ensuring people were cared for safely because one care staff was expected to support people when it would be unsafe to do so. There was also a risk to people as staff had not been adequately trained to use the equipment which was in place to assist people to move safely.

There had been an incident reported to us in January 2016, which related to a problem with the electronic rostering system. This has resulted in missed calls for some of the people who used the service. We discussed this with the registered manager who told us they were investigating the matter. We asked how many calls had been missed in total. The registered manager was not able to tell us because they had not taken the necessary action to find out which calls had been missed. The registered manager told us they were 'using the opportunity' to visit all the people who used the service and to review their records. This meant the registered manager had not taken timely action to establish the impact to the people who used the service or assess the impact of any missed calls. The registered manager did tell us one person had gone without care for a period of 21 hours, a period where there should have been five visits carried out.

There had also been an incident reported to us in April 2016 where staff had refused to care for people because they had not been paid on time. This was due to a change in the process for wages to be paid which had led to an error and delay. The actions of the registered manager and the staff meant people were put at risk of not receiving the care they needed.

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

We looked at the records relating to the administration of medicines. We found there was conflicting information recorded in people's care files. It was unclear what level of assistance people required from the care staff who attended them. There was evidence in daily records that medicines were being administered by staff, yet the care records did not make clear this was to happen. Medication Administration Records (MARs) were not brought into the office regularly to be checked by senior staff to identify any errors or issues which may have occurred.

This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as there was no clear guidance to tell staff what level of assistance they should be providing or why this was needed.

We looked at the risk assessments which were in place. We found there were very few risk assessments in all the files we looked at. In cases where there was a risk assessment this was called a 'baseline assessment'. This was a generic risk assessment which did not allow specific risks to be identified or the measures which needed to be in place recorded. We did not see these documents in people's homes when we visited them. We asked the manager about risk assessments; they told us, "They should be in place in everyone's homes". We asked if they had been working on these since being in post. They told us they had, but not for the service in Wakefield as yet. This meant the registered provider had not taken appropriate action to identify and minimise the risks to people who used the service. The manager told us the risk assessments were now stored online. When the manager attempted to access these documents they were found to be blank. The manager told us this was because they had changed electronic systems and the information, "Must not have transferred across properly."

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

People who used the service told us there had been issues with staff not wearing uniform during care calls. This posed a risk to people because uniforms identify staff and reassure people that people entering their homes are employed by the care provider. Uniforms are also designed to be worn to prevent and control the spread of infection. Some people told us this had improved recently, however people said this did still happened sometimes.

Inadequate

Is the service effective?

Our findings

One person who used the service told us in relation to the use of their hoist, "They are supposedly trained, but when they send the young ones they stand back and watch the other one do it."

The recruitment coordinator told us, "The registered manager did all the induction training; since they have been away we are using e-learning. Moving and handling is done online and then being assessed in the community by more experienced staff."

We looked at staff training. This was difficult to assess as there was a training matrix being created, however this was not complete. We could not verify the level of training for individual staff as their certificates had not been filed, and were left in the envelopes they were received in. Staff told us they were now doing their training on-line. The recruitment coordinator told us this included medication training, which they told us staff were only able to prompt. This was not the case from the daily records we saw which stated medication was administered.

We looked at supervision, quality checks and appraisals. We found there were very few carried out since the previous inspection. The manager who was present at the inspection told us they were not aware of any supervisions or appraisals being carried out, but they had completed two unannounced quality checks recently. There was no clear process for staff to be supervised, quality checked or appraised; however the manager told us they intended to supervise staff every six weeks.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider could not evidence that staff were suitably trained and there was not appropriate support in place for staff.

We looked at the records related to the previous breach of Regulation 11 regarding the need for consent as mental capacity assessments had not been in place regarding people's capacity to make decisions in relation to their pain medication. We did not see any mental capacity assessments in the care records we reviewed for people who were receiving assistance with the administration of their medicines. It was also very unclear from people's care records what level of support they required and why this was the case.

We reviewed people's care records to ascertain whether the registered provider had sought and gained people's consent to the care they were being provided. We saw there was no evidence in any of the files we looked at that people had been asked for or had signed the documentation to give their consent. There were no mental capacity assessments in the files we looked at to show whether people had the capacity to make decisions about their care needs, there were no records to show where people did not have capacity their relatives had power of attorney or whether there was anyone acting as an advocate for people.

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

We looked at whether care staff supported people to maintain good levels of hydration and nutrition, however due to the lack of records we were unable to evidence this was the case. We identified one instance where a person had been left without hydration and nutrition for a period of 21 hours due to missed calls. We looked at how Roses Socialcare supported people to maintain their health and to access other healthcare services. We were told by families that they managed their relatives healthcare needs. We did not see any records which showed referrals had been made to other healthcare professionals on behalf of people who used the service. People who used the service confirmed that care staff did contact the office if they were concerned and had on occasion rung their relatives to let them know if they were concerned.

Requires Improvement

Is the service caring?

Our findings

One person said of a member of staff who visited, "They are quite amiable, but their heart isn't in caring, they are from the office. They are scared of hoisting." Another person told us, "In the main we have had good carers, we have had a few hiccups though." A relative told us, "They are usually very good; when the main carers come it is good. Another relative told us, "They are lovely, they listen to what I tell them and we have a laugh."

People who used the service told us staff treated them with dignity and respect and were kind in their approaches. We did not observe any interactions between staff and people who used the service during our home visits, as these did not coincide with any planned visits. People were generally happy with the way in which staff conducted themselves, however there were some concerns raised about some members of staff who had acted unprofessionally by sharing very personal details of their personal lives which made people feel uncomfortable.

The manager told us there had been some issues involving staff who had breached people's confidentiality whilst caring for people in their own homes. The manager told us these staff had left the service during the investigation and disciplinary process. There were confidentiality agreements in place in staff files, however these were not always completed or signed to make them valid and there were no processes in place to check whether people felt their confidentiality was being respected.

We looked at people's care plans and found there were no references to people's cultural or religious needs or preferences despite the service being situated in an ethnically diverse area. There was also no reference made to whether people had been asked about their wishes for the end of their lives, which would be necessary as the service cared for older people and people who were at the end of their lives.

Staff and people who used the service told us there had been inconsistency in the staff who attended people regularly, which had settled after a period. However, the lack of staff in the service generally meant that staff were working extra hours and were not attending their regular calls. People also told us they felt at times the times of their calls had been moved to suit when staff were available and no thought was given to whether this met their needs. One person told us, "When we started the service we were told they were allowed 15 mins leeway on the agreed call times, they kept coming very early or very late. When we took this up with them [registered manager] they told us their policy was two hours leeway, that can't be right surely?"

We asked staff how the service kept people informed. Staff did not know of any ways in which this happened. The registered manager told us they kept in touch with staff via text messages.
People who used the service told us they were not always informed if care staff would be very late, and were not informed at all if only one member of staff was attending when the person required two members of staff to assist them.

We asked people if they were kept informed of changes in the service. People told us they were not and that the office staff changed regularly, which meant they did not know the people they spoke to in the office and

did not have the chance to build any trust with staff.

We did not see any evidence in any of the care records we looked at that people had access to advocacy services. An advocate is a person who supports a person who may not have capacity to make certain decisions without assistance or who finds it difficult to communicate their wishes and preferences. We saw there were people's next of kin recorded in care records. There were, however no records to demonstrate people's capacity had been assessed where there was reason to believe this was in question as some people had a diagnosis of dementia or had other cognitive impairments, or that their next of kin had been given the opportunity to be involved in the planning of their care where this would be appropriate.

We looked at whether care plans reflected people's need to be encouraged to be as independent as possible. We found there were some references to this in some of the care summaries we reviewed for example 'remember to ask the person whether they can do it themselves', however these were generic phrases and were not specific to the person about who the care plan was written.

Inadequate

Is the service responsive?

Our findings

People who used the service told us, "I ring the office when I need to complain." A relative also told us they had called the office to raise concerns about the lack of consistent staff their relative had been receiving; they told us this had been addressed.

People told us they had raised concerns with the office and whilst some people told us their concerns had been dealt with, we could find no evidence these concerns had been recorded. The complaints file had no recent complaints and none recorded since our previous inspection in October 2015. This meant the registered provider was not recording and investigating complaints in line with their own policies and procedures.

This was a breach of regulation 16 receiving and acting on complaints of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as complaints were not recorded and there were no records of the investigations or actions which had been taken to resolve the complaints.

The care records we reviewed which were stored in the office were incomplete. In some cases there was no file and only loose documents in a filing cabinet. In other cases there were files, but the contents varied from file to file with no consistent format being evident. We were told some of the care plans were now created and stored electronically, however we saw no evidence of these in the office or that these had been put into place in people's homes for the care staff to use. In some of the files we saw there was a 'summary care plan'. This was a basic care plan which listed the tasks which were to be carried out at each visit. There was generic information on the conditions which a person was diagnosed with but there was no personal information on how the condition affected the individual. The manager who was in post at the time of inspection told us they were in the process of reviewing and re-writing the care plans for each person, however they were not able to evidence any progress had been made for any of the people who used the service.

We looked at the care records of the people who used the service which were kept in their own homes, and the files which were kept in the office. We found the documents which were kept in people's homes were simply a contract of service which had lists of tasks to be undertaken at each visit. We did not see any person centred care planning which would allow care staff to be able to meet the needs of the person they were caring for. We also noted there were no risk assessments in the files in people's homes, either in terms of their care and the potential risks of tasks such as using a hoist to assist a person to transfer, or for the environment to assure staff the person's home had been assessed as a safe work area. There were some risk assessments in the files stored in the office; however these were not in place in all files and were generic forms which did not identify specific risks or set out the measures which needed to be in place to minimise those risks.

When looking at the care records for people who used the service we could see no evidence that care plans were reviewed to check they were up to date and addressed any changes to people's needs which had taken place.

This meant people's care plans were not person centred or accessible to care staff; because if they were stored on the computer system care staff would not be able to access them. This was a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the daily records which were stored in people's homes and in the office. We found there was little evidence in these records that people had been offered choice during their visits. Staff we spoke with told us they offered people choices and gave examples of how they would do this, for example in what clothes people wanted to wear or what they wanted to eat.

Staff and people who used the service told us there was a lack of communication from the office. This was in relation to changes to people's calls times and being informed of changes to their rotas. Both people who used the service and staff felt this was detrimental to the quality and safety of the service. People who used the service told us they would not call the office team as they did not receive any feedback on matters when they had in the past. This meant people were not reporting their concerns as they did not feel they would be listened to or any action would be taken by the registered manager to resolve their issues.

Inadequate

Is the service well-led?

Our findings

There was a registered manager at the time of inspection; however we had been notified they were taking a leave of absence. There was a manager who was new in post, who was responsible for the day to day running of the service but who was present only during the afternoon of the inspection.

A person who used the service told us, "I have met a few managers, they never stay long." There were a lot of problems recently with a new manager, they came in and upset everything. I had lots of different carers all the time. They are not there anymore." Another relative told us, "When the registered manager was there, before they went off, they were calling me all the time asking to change the times of the calls and telling me when I could have my sits, it was really upsetting."

During the day of the inspection there were three members of staff who worked in the office, however there were three periods of approximately 20 minutes where there were no staff in the office and it was unmanned despite being accessible to people via the community centre. Phones were ringing and there was no evidence calls were diverted to another number during these periods. When the manager arrived at the office in the afternoon the only person who was in the office was one of our inspectors. This meant confidential information was at risk of being accessed and there was no-one available to answer the telephones during these periods.

Staff we spoke with told us there was poor communication with the office; there had been issues with staff not being paid consistently which had caused them hardship. Staff reported having been asked to pick up extra hours 'all the time', there not being enough staff, and there being a high turnover of staff and sickness. Staff told us there was poor morale within the community team and they did not feel supported by the office team or the registered provider.

During the inspection we interviewed the manager who was in post and asked them what their priorities were to improve the service. They referred to how they would prioritise updating and reviewing care plans, however they did not have any plans in place beyond this aspect of the service.

At the time of the inspection there was a care coordinator, an administrator and a recruitment officer present in the office. We found there was lack of communication between the staff team and the manager, as when we asked for information staff were not able to tell us where this was stored and did not know how to access information which was stored electronically. We asked to be shown risk assessments which we were told had been recently completed by the manager. The office staff could not access these and contacted the manager and, despite speaking to the manager, staff were still not able to access these key documents. The manager arrived at the office later in the afternoon and was unable to access any completed risk assessments on the electronic systems, although they could demonstrate blank templates.

The manager told us the issue was caused because all the electronic information had been moved from one system to another and this must have 'blanked the documents'. The manager told us none of the staff had been given any training to use the new system and no checks had been made to ensure the information had

been transferred successfully.

We identified at the last inspection that the processes which were in place to monitor the quality and safety of the service were not adequate and were not being kept up to date. There were also concerns shared that there was no evidence the information had been analysed or used to inform planned improvements. At this inspection we found there had been no auditing carried out since the last inspection and no processes had been put in place to monitor quality and safety. This meant that whilst the registered manager was on their leave of absence there was no oversight of the service available to them or to the registered provider to allow them to be assured the service was safe and of good quality.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as there were no systems in place to allow the registered provider to have oversight of the service.

We looked at records which were kept in relation to recording significant events in the service and we found there were concerning gaps in the information which was being recorded in relation to incidents of concern, accidents and safeguarding concerns. We found the registered provider had not met their regulatory responsibilities by informing us (CQC) of all notifiable events including safeguarding concerns.
This is a breach of Regulation 18 (2) Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009.

There was a very evident lack of leadership in the service, as the registered manager was absent, the manager who was new to the service was new in post and the office team were not long standing or experienced in the type of care provision the service was delivering. People who used the service told us management changed regularly and reported the registered manager was not a positive influence on the stability of the care they received. One person told us, "It has been less stressful since they [registered manager] went off, I don't get the calls changing calls all the time now."

There was no clear line management structure in place and there did not appear to be clear roles and responsibilities for the staff who were employed in the office. The manager told us the recruitment officer, the care coordinator and they were providing care calls regularly because there were not enough staff to cover all planned calls, which included sitting services to allow family carers free time and to provide respite from their caring responsibilities.

People who used the service told us the out of hours on call service was often answered by the administrator, who we were told did not have a background in care or any experience of delivering care. The manager told us this was not the case; however people who used the service were clear this was the person who usually answered the calls during out of office hours. This meant that whilst there was reported to be a second person on call who could be contacted in case of emergency, this would result in a significant delay in support being available to staff who were needing immediate responses.

During conversations with the manager and subsequently the registered provider, there appeared to be little understanding or awareness of the level of failure we found in the service, and there were no plans in place to demonstrate the issues had been identified and the need to take immediate action to improve services had been recognised and acted upon.

We found there were multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, some of which were continued breaches from our last inspection and where action had not been taken to resolve the shortfalls. There had been a significant deterioration of the standards of care

plans, risk assessments and records since the last inspection, and there was no evidence that improvements had been made in any area of the service.

The registered provider had made multiple changes to the systems which were in place to manage key functions of the service, including rostering the planned visits. This had led to missed calls which put people at risk. There had also been decisions made which had impacted on the payment of staff, which led to staff refusing to work which also put people at risk.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider was not consistently reporting all matters which are notifiable under the terms of registration

The enforcement action we took:

Notice of proposal

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were inadequate where they were in place and in some cases there was no care plan. Care plans were not consistent in the information presented and would not allow care staff to meet the needs of people who used the service. There was no reference to people's wishes or preferences in the care plans which were seen.

The enforcement action we took:

Notice of proposal

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent There were no assessments carried out in relation to people who may lack capacity to make their own decisions in relation to their care and medicines. There was no evidence of advocates being used or lasting power of attorney orders. People were not asked to give their consent to the care which was to be delivered to them, and care plans were not signed.

The enforcement action we took:

Notice of proposal

Regulated activity	Regulation

Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The risk assessments which were in place were generic and were not decision specific. There was no clear explanation of what the identified risk was or what measures were in place to minimise the risk. The care plans were unclear in what level of assistance people needed with their medicines. There were no processes in place to monitor the competence of staff who were assisting people with their medicines and medication administration records were not checked.

The enforcement action we took:

Notice of proposal

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding was not recognised and reported consistently. There were missed and late calls regularly, and instances of one member of staff arriving to carry out a call requiring two people to assist them. Staff not being paid led to staff refusing to carry out routine care calls.

The enforcement action we took:

Notice of proposal

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not recorded consistently, there was very little evidence of how complaints had been dealt with and the outcomes of those complaints.

The enforcement action we took:

Notice of proposal

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There were no processes in place to monitor the quality and safety of the service. The registered manager was on a leave of absence and there was no oversight of the service from the provider

during this time. The shortfalls had been identified at the previous inspection and had not been addressed. There were failures in the service which were unidentified by the manager as a result.

The enforcement action we took:

Notice of proposal

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff were not safely recruited. We found there were staff who were listed as working for the service for whom there were no staff files. The recruitment files were incomplete and there were not sufficient employment references carried out. we found instances where staff had failed to declare convictions and had not been challenged about this when this became apparent. There had been no risk assessments carried out in these cases to ensure staff were suitable to work with vulnerable people

The enforcement action we took:

Notice of proposal

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to meet people's needs consistently and in a timely and safe manner. There were instances of missed, late and calls which required two staff members only being allocated one. Care calls were moved to times when staff were available rather than to meet the needs of people who used the service and their families.

The enforcement action we took:

Notice of proposal