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Supreme Healthcare Services

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection was announced and took place on the 14 and 15 April 2015.

Supreme Healthcare Services provides personal care and support to people who live in their own homes. At the time of the inspection they were providing personal care to 38 people.There was no registered manager in place. 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 a have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People using the service told us they felt safe however care worker practices did not always reflect safe care. People's safety had being compromised in a number of areas. This included being exposed to avoidable physical harm and the unsafe management of people's medicines.

Summary of findings

Care workers did not always demonstrate that they had the required knowledge to be able to safeguard people and report any concerns to the relevant safeguarding authority. There were not always personalised risk assessments in people's care plans detailing actions that needed to be taken to ensure a person's safety when care was being delivered.

There were insufficient staffing levels to ensure that people's needs were being met safely. There were also insufficient contingency plans in place in the event of adverse situations such as poor weather conditions to ensure that people still received safe care. The provider did not have a system in place to ensure the continuous assessment of staffing levels to ensure they continued to meet people's needs. When additional care workers were required the provider did not seek assistance from partner domiciliary care agencies to ensure there were always sufficient care workers to meet people's needs safely.

The provider did not operate a safe and effective care worker recruitment system. People were put at risk because when Disclosure and Barring (DBS), criminal records checks revealed care workers had relevant records, no actions or risk assessments were in place to assess or mitigate against any risk.

Medicines were not always being provided to people by care workers in the way they were prescribed or wanted. The Medication Administration Records (MAR) were not completed correctly so it could not be established whether medicines had been administered to people.

Care workers demonstrated that they understood person centred care but were not supported by the provider or through training to deliver this. Care workers did not receive robust training upon induction and it was unclear what training they had, or had not received. Even though some care workers had received training in the Mental Capacity Act 2005 (MCA) they were unable to demonstrate their understanding about how it could affect the care they provided.

People had not always been supported by care workers to access, when needed, health care professionals. When risks had been identified and harm had been caused no health care professionals advice had been sought by care workers to maintain people's safety and welfare.

The provider was not operating in the best interests of people using their service because their views and experiences, when negative, weren't being addressed.

The provider's vision and values for the service were not known or understood by the care workers and therefore could not be delivered to people using the services.

Quality assurance processes were in place but not being used regularly or effectively to gather, capture and then respond to concerns when they were received. People told us they weren't able to get their concerns addressed when liaising with senior management.

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

After the inspection the provider voluntarily submitted an application to remove Supreme Healthcare Services (Basingstoke) from their registration under Section 19 of the Health and Social Care Act 2008 (as amended).

This meant the provider would no longer be registered to conduct carrying out the regulated activity of personal care from this location.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

The provider did not have robust recruitment process to ensure that people were cared for safely.

Care workers were able to identify the differing signs of abuse and the need to report these. However the provider was not sure of the correct procedures for informing the relevant authorities, including the Care Quality Commission (CQC) to protect people from further harm.

Individualised risk assessments were not always in place to ensure that people were protected from the risk of harm.

Contingency plans were in place to cover emergency situations such as flood and adverse weather situations. However there were insufficient numbers of care workers to follow the guidance to ensure that people were kept safe.

Is the service effective?

Inadequate

The service was not effective.

People were not always supported by care workers who had the necessary skills, knowledge and confidence to meet their assessed needs.

Not all care workers had received training in the Mental Capacity Act 2005 (MCA) however those we spoke with were able to describe their responsibilities to ensure they had gained people's consent prior to delivery of care.

People were not always being supported or encouraged by care workers to eat or drink sufficiently to meet their needs.

The provider did not make sure that people were supported to maintain good health and able to receive healthcare professional visits whenever required.

Is the service caring?

Requires improvement

The service was not always caring.

Care workers were motivated to develop positive relationships with people however were not always given sufficient time by the provider in order to do so.

People did not feel that they were always involved with the provider in planning and documenting their care to reflect their needs and preferences.

Care was not always given in a way that was respectful of people and their right to privacy whilst maintaining their confidentiality.

Is the service responsive?

Inadequate

The service was not responsive.

Summary of findings

People did not always feel that their care plans were personalised to their requirements or requests.

Feedback received from people and their relatives as complaints or in response to questionnaires about the service were not reviewed by the provider to enable the development of action plans to drive improvements.

Is the service well-led?

Inadequate

The service was not well led.

People and care workers did not feel that there was a positive culture which allowed them to share views on how to improve service quality.

There was no registered manager at the location and the providers values of the were not known and always demonstrated by the care workers.

The provider did not have effective systems to regularly assess and monitor the quality of its service. There was no system to promptly identify missed calls. Ineffective quality assurance systems meant there was the on-going risk to the health, safety and welfare of people.

Supreme Healthcare Services

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

This inspection took place on the 14 and 15 April 2015 and was announced. The manager was given 48 hours' notice of the inspection as we needed to be sure that the office would be open and that care workers would be available to speak with us.

The inspection was conducted by two inspectors and an Expert by Experience who spoke with people using the service and their relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at the previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law. We also looked at the provider's website to identify their published values and details of the care they provided.

The provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give us key information about the service, what the service does well and improvements they plan to make.

We visited the agency's office, met with three people at their homes, spoke with the manager, the quality improvement manager, three care workers and two relatives. We looked at four people's care plans, daily care notes for two people, five care worker recruitment and training programme files, care worker rotas for the dates from the 23 March until the 12 April 2015, the care workers training plan, quality assurance audits. We also looked at the provider's records for monitoring completed and/or missed care visits and policies and procedures. We also spoke on the telephone with an additional two care workers, four relatives and three more people who use the service.

The previous inspection was carried out in August 2013 and no concerns were raised.

Inadequate

Is the service safe?

Our findings

People told us they felt safe when the care workers were present providing their care. One person told us "I like the carers, I always feel safe". A compliment from November 2014 was seen which stated, "feel safe with her, like having a family member in the home." However, we found practices identified within the service were not always consistent with most people's positive views about their safety.

Even though seven people said they would have been confident to speak out about any form or abuse and harm, or associated risk of harm, one person disagreed with these comments. They told us that when they had been expecting to receive two care workers to deliver care only one person had arrived. This had occurred on a number of occasions and led to a relative, with no formal training, having to intervene to assist in the delivery of care. This had left the person vulnerable to the risk of receiving unsafe treatment. This had also caused emotional distress to both the person and their relative.

People were not always protected against the risk of abuse or harm as care workers were not informed by the provider on how to report harm or suspected harm. Care workers were able to evidence their understanding of the types and incidents of abuse which are safeguarding concerns. However, safeguarding incidents were not always being reported to the relevant authorities for investigation. These investigations would identify where practices had failed and assist the provider in making improvements to ensure people were kept safe. The provider had a safeguarding policy but it did not correctly identify where such concerns should be reported. One care worker said they had never seen the policy and another said they knew it was in existence but had only "glanced at it".

One person told us they had received an injury to a highly sensitive part of the body when a care worker had removed an item of medical equipment in an unsafe fashion. This had caused the person considerable physical and emotional distress. However this incident had not be reported to the local authority for investigation. The Care Quality Commission (CQC) had also not been notified of the incident, which was a condition of the providers registration. Care workers did not know where to report safeguarding incidents other than speaking with their manager, one told us "I know you would speak to someone higher, but I don't know who that would be". Only two members of staff had been able to demonstrate that they had contacted the Local Authority previously to report safeguarding concerns but they had not known the need to also report to the CQC.

Processes were also not in place to ensure the safety of vulnerable service users at risk of psychological harm. A safeguarding referral had been raised directly with the local authority by a concerned care worker alleging an inappropriate relationship between a service user and a member of care staff. Assurances had been made by senior management to the local safeguarding team that care would not be provided by this member of staff whilst the investigation was conducted. However we identified on a number of occasions that this care worker was scheduled to deliver personal care to this person. The quality improvement manager identified that there had been a breakdown in communication when the information had been discussed and not passed to the person who was organising the care staff rotas. This was addressed on the day of the inspection and the care worker placed on the "exclusion list" so they would not be sent to that person's address.

People were not protected against the risk of abuse because care workers had not been trained and did not have guidance to know how to respond appropriately.

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

Risks to people's safety were not always properly managed by the provider. A risk assessment had not been completed where there were serious concerns regarding a domestic situation which had been raised by the local authority. Not all care workers were aware of the risks to the service user or themselves as a result of this situation. The manager told us "some of them (care workers) know". The quality improvement manager was asked about the situation and told us "there are not risk assessments; I do agree….there should have been clear guidelines, that are not there".

Another service user who had been with the service six weeks had a partially completed Waterlow assessment in their care plan. A Waterlow assessment is a tool which is used to give an estimated risk for the development of a pressure sore in people who are vulnerable. The scores for the individual questions had been completed by a care worker but not totalled at the end of the document.

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Is the service safe?

According to the assessment the total score placed this person at 'high risk' and stated the 'need for further risk assessment and management'. However, there were no risk management plans in place as a result of this score. No referrals by the provider had been made to other health care professionals to ensure that the risk was managed appropriately.

The provider did not always ensure that care workers were aware of guidance and procedures in place to assist them in their work. Even though there were policies and guidance in the event of an emergency such as a flood or adverse weather care workers were unaware of their existence. One care worker told us they didn't know what an adverse weather policy was and another said they had never been informed about it. The manager told us there were not enough staff to be able to meet the requirements of the emergency procedures which would leave people vulnerable.

People were not always receiving treatment which kept them safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were insufficient care worker numbers to keep people safe and to meet their needs. People told us that care workers were often late or missed visits completely. When asked about staffing levels people told us, "they are late at least once a month every month", "they do not turn up two or three times a month" and "a neighbour had to give my relative medication when I was away". The manager told us vulnerable people were at risk as there were not a sufficient number of care workers to ensure people were receiving their care.

Even though this inspection was announced on both days the manager and the Quality Improvement Manager had been scheduled to deliver care. The manager told us that this was a result of having insufficient numbers of care workers to cover their rotas.

On the 1 April 2015, as a result of a number of complaints to the local authority about missed care visits, the provider had been asked to assure the local authority that they would no longer occur. The provider made assurances that care workers would be sought from other agencies within their consortium, however this was failing to happen and care visits continued to be missed.

This was having a direct impact on people using the service. One care worker told us about one particularly vulnerable person who lived by themselves whose needs were not being met when care workers were unable to attend scheduled appointments. A relative told us their family member had been without food for 12 – 14 hours because care workers had been unable to attend their appointment.

One care worker told us that a large number of care workers had left recently and that office staff had to deliver care. They told us "we just keep going until we can cover them all, which is why we are all so tired". The manager had collapsed with hypertension after working 17 days without a day off in order to try and fill the short fall in staffing numbers. When we asked the manager on the second day of the inspection to make provisions for additional care workers to be brought in from partner agencies to assist none were available.

The provider did not have a system for reviewing people's care needs and ensuring there were always enough care workers employed to provide care to meet people's needs and protect them from harm. There were no arrangements in place to make sure people received the care they were expecting when care workers did not arrive to care for them. There was a failure to make sure that enough care workers were deployable to ensure people received their care visit including food, drink and medicines at a suitable time.

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

Safe care worker recruitment procedures were not always followed by the provider.

The provider had not always checked that satisfactory references to ensure proof of satisfactory conduct in previous health and social care employment, full employment histories or Disclosure and Barring service (DBS) checks were obtained.

The DBS enables employers to make safer recruitment decisions by identifying candidates who may be unsuitable to work with vulnerable people. People with references from previous employers who had identified them as poor in areas such as attendance/sickness/reliability - honesty and trustworthiness were employed without further

Is the service safe?

investigation. People with criminal histories were also employed without any additional risk assessment in place to identify how risks to vulnerable people would be minimised.

There had been an impact on as one person had suffered thefts of over £300 in cash from their home address.

This was a failure to implement a thorough recruitment practice to ensure that care workers were suitable to work with people.

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

The provider did not have appropriate arrangements for the recording, using and safe administration of medicines. Records did not accurately show whether people had taken their medicines or not. One Medication Administration Record (MAR) sheet viewed showed significant gaps on continuing medicines. From the 1 April until the date of our inspection it appeared that one person had only been administered their blood pressure tablets on 2 out of 14 days. There was no record of whether they had refused their medicine or whether a referral had been made to the GP in the event of frequent refusals. This person had previously suffered a stroke making them even more susceptible to incidents of high blood pressure.

The provider's Medication Policy read, "medication must not be crushed or capsules split to give to service users as they may affect the way medicines work and can be potentially harmful to the service user". A relative told us that care workers were opening medication capsules and placing this in their family member's porridge for consumption. The person knew their medicine was being administered and didn't like it being delivered in that way. They identified to us steps care workers needed to take so they could self-medicate however this was not the method used by all care workers. There was no record of a referral to a GP to ensure that the medication could safely have its form changed by mixing with food for consumption. This was brought to the quality improvement manager's attention on the day it was identified. Care worker meeting notes from October 2014 identified that MAR charts were being incorrectly completed but no further action was taken by the provider to ensure the care workers involved were subject to additional training or disciplinary procedures.

People weren't always being protected from the risk of infection. Suitable procedures were not in place to make sure that infection control practices were followed by the care workers. We were shown images of the home environment of a person who had been receiving care. Personal incontinence care items which had been used were left unwrapped in the person's bathroom, food hadn't been safely and hygienically stored and flies were surrounding a broken fridge in the person's house. This person was in hospital suffering with an infection during this inspection.

Complaints had been received by the provider from a relative indicating that once personal care had been delivered the care workers were leaving the used gloves on the person's table which was used for food. Even though the provider had guidance on the safe disposal of items used to deliver personal care this was not followed by all the care workers. Care workers were also at risk of transferring infections and illnesses to people. During the inspection we heard a care worker call the office who was upset as they had been physically ill and weren't able to attend work. They then arrived at the office in uniform in the afternoon telling us that the quality improvement manager had requested they attend work. This person had been sick and had been scheduled appointments with people all afternoon. They were a risk to themselves and to people using the service so we asked them to refrain from work.

The provider's 'New Care Workers Fact Sheet' stated that in the event of sickness absence, "we expect you to be prepared to cover your first 2 – 3 calls in the morning as we will need time to cover your calls that day, if you have not informed us the day before". The provider's policy CC34 Infection Control Staff Sickness said that "staff with diarrhoea and vomiting should not attend work but to ring to report sick. Should not return to work until medical clearance by a GP is given".

This failure of the service to implement and monitor effective infection control practices was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People had differing views about how effectively the care workers cared for them. One person told us, “the carers ask for permission, consent all the time”. Another person told us they had a regular carer but when it was their day off, “I always think, oh God what’s going to happen each week”.

Care workers had not received effective training, support and supervision from the provider to enable them to complete their roles safely . The provider also did not have an effective system in place to monitor that care workers were suitably trained to carry out their roles and provide appropriate care. Training records did not show when care workers had completed training and when they were due to undertake an annual refresher in core areas of training.

The provider showed us documentation which detailed a nine day induction process that all new care workers were required to complete. This initial training was followed by a computer based training programme which had to be completed within 12 weeks of starting with the service. This learning was supported with practical experience of shadowing a more experienced care worker for two shifts.

This structured induction process was not always completed by new staff. One care worker told us they were delivering care after only three days training, another said they had four days in office training, had two shifts shadowing then they worked alone unsupervised. Another care worker said they had three days training, watched some videos had two nights shadowing and then worked alone unsupervised.

This meant that people may not have received care from care workers with the appropriate skills and knowledge base to meet their needs. One person had received care from one care worker on two occasions who did not know how to support them with their continence aids. This had distressed this person who told us they had, “novice carers”, who “didn’t know what they were doing”.

The provider’s ‘New Workers Fact Sheet’ stated that all care workers would receive regular supervisions. These were to occur weekly in the first 12 weeks of employment and then to continue on a once a month basis. One care worker told us that in the first 4 months of employment they had not received one supervision or appraisal. They were told upon starting employment they would be contacted by telephone after their first day, then after the first week they would be invited into the office. The care worker told us that this hadn’t happened. Another care worker told us they had not been in a position to complete spot checks on people’s competencies as they were always out delivering care. Only one care worker and the registered manager was able to tell us that they had received a formal supervision in the last four weeks.

The provider did not ensure that all care workers received training about the Mental Capacity Act 2005 (MCA). Only seven out of the 16 care workers had completed MCA training, however, most of the care workers we spoke with were able to describe their responsibilities relating to the MCA. This included how people’s capacity to make different decisions should be cared for and supported.

Care workers we spoke with identified the importance of obtaining consent prior to delivering care and were able to evidence how they did this. People confirmed that care workers would always ask permission prior to delivering their care.

Care workers were not always able to recognise and deal with people exhibiting behaviours that may be challenging.. A Senior manager told us about a person living with Dementia who would sometimes communicate in an aggressive way. This senior manager explained that this person was exhibiting challenging behaviours because they were upset at the care they were receiving. A care worker told us that another senior manager would speak over this person stating that they would be abused and, “it would be better not to listen to him”. No risk assessments or assessments had been completed regarding this person which meant when care workers were faced with behaviours that may challenge they were unable to support this person effectively to keep them safe. On one occasion this had led to a care worker having to leave the location and the person going without all the care required during that visit, which caused this person distress.

People were not always supported to eat and drink sufficiently to maintain a balanced diet. One relative told us that care workers weren’t supporting their family member to eat and drink well. They were failing to monitor what they were eating, giving them, “whatever”, and that care workers were unable to cook their food properly. On one occasion the person had not had their cold drinks changed for over five days. Another complaint had been made to the

Inadequate

Is the service effective?

provider from a relative as a result of their family member not receiving a lunchtime call which meant they had received no food and medicines. This person had a medical condition and on that day suffered a fall.

People were not always supported by care workers to seek additional medical support when required. A compliment slip from December 2014 stated that the person was, "impressed with how the office team liaise with other professions such as occupational therapists and GPs." However, we could not see that this was a consistent practice. Care workers were able to provide evidence about when they had identified health care issues and referred them but this was not happening for all people.

A care worker had identified a person requiring additional support in their daily routine and repeatedly contacted office staff to alert them to this, they were not listened to. It was only on intervention by a paramedic and a family member that a reassessment of this person's requirements was made. People may not be receiving the appropriate care they need at a time which is appropriate to manage any risks to prevent any harm. The provider had not ensured that referrals to healthcare professionals when required were always made. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service caring?

Our findings

People and their relatives' views about the quality of the care and caring attitude of care workers varied. The majority of people we spoke with were very complimentary about the care workers. One person told us, "they are very caring, they have compassion and are polite", a relative said, "they are always respectful and treat my husband with dignity he deserves". Other people told us, "she (care worker) is the best" and "the carers are good, they treat me with respect – very polite".

However there had been occasions where people told us that their relatives could have been dealt with in a more caring way. One relative told us that care workers would routinely say, "is he in one those moods today". They continued, "It's not like they care anyway, they just come in to do a job". Another relative told us about a situation where a care worker had a piece of continence equipment moved which had caused the person to cry out with pain. This was responded to by a care worker telling the person to not, "not be such a drama queen", which had caused additional distress. This evidence showed that people were not always protected from abuse or improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working practices didn't always allow positive relationships to be maintained and developed between care workers and people. Care workers were often provided with little or no travelling time between calls which meant they would often have to return scheduled calls to the office as they would be unable to complete at the scheduled time. Worker schedules were seen for three weeks prior to the inspection which showed that care workers were routinely scheduled to finish delivering care at one location at the same time that their next appointment commenced elsewhere.

Care workers told us they didn't always have knowledge of a person before delivering their care for the first time. The provider did not ensure that care workers had time to read care plans and understand the preferences of people before attending to support them. Not all of the care plans viewed had personal histories with information regarding that person's hobbies, likes and dislikes. One care worker told us, "they (provider) just get us new people, they don't tell us anything about them…don't tell you a thing, we've just got a blind man, no one told me he was blind so I didn't know for ages". Another care worker told us that, "some care workers aren't aware of their full duty of care" and that, "people's standards have slipped". One relative told us that care workers had "left my Aunt on her own when very distressed". Another relative said that when a new care worker would arrive, "you have to explain everything and by the time it's taken you might as well have done it yourself." The manager told us that care workers were not given the time to shadow regular care workers for people in order to create a rapport before delivering care. The manager had recently had to deliver care and told us, "it was awful because I'd never met her before".

These examples show that care wasn't always being delivered in a way that was person centred and able to meet their needs.

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

Care plans viewed showed that people and their relatives had been involved in designing the care that they wanted and needed. They were signed by relatives, where applicable, and detailed with exactly the routine people required to enable them to live as independently as they wanted. In one care plan instructions were provided by the person as to how they wanted their hoist to be used. Care plans, when reviewed, where being done so with people and their family and or social workers to ensure their needs were being documented.

People told us about care workers, "they are very caring and treat as a respectable individual", and "they treat her with respect and dignity, no rush at all". However we were told of occasions where people had not had their privacy or dignity respected or promoted.

One person told us that a senior manager had left them naked and uncovered on their bed after delivering care. Their relative had had to intervene and call the care worker to return in order to ensure that person's dignity was respected and they were appropriately dressed. We were told by a number of people that a relative of the provider had been completing an internship at the location. During this he had been placing and receiving telephone calls to both care workers and people using the service. On one occasion he had been heard arguing with a person who had called about a missed visit. This person told us they had not been treated with dignity or compassion.

Requires improvement

Is the service caring?

People's personal information was not always treated confidentially by care workers. Prior to the inspection we were told about a referral which had been made to social services about a breach in confidentiality. A person using the service was made aware that care workers had been discussing their personal health situation in front of another person using the service. This had been reported to the provider and subsequently social services. Team meeting notes for September 2014 stated that prior to this incident in January there had been previous breaches of confidentiality.

These were failures to ensure that people's privacy and dignity were being respected and promoted.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

People didn't always feel that the service was responsive to meeting their needs. One person told us, "I was going days without anyone bothering, if they miss a call I don't get food". People told us that when they complained they didn't always feel they were listened to, "when I complain, the issues are not resolved". Another person had written in a quality assurance questionnaire dated April 2015, "I never know who is coming and I do know they change them and don't tell me. Office people do not listen to my complaints".

The provider told us before the inspection that people's care plans were being audited every three months. This was to ensure people's changing needs were being identified and that care could be amended accordingly. The quality improvement manager told us that this was not happening due to a lack of care workers. This was confirmed by the manager. One person told us, "I have tried to negotiate my half hour slots, but they have not done anything".

Care plans showed details of the routine and support required for people on a daily basis. The daily records, detailing the care delivered at a visit, were also completed effectively. However, not all care plans viewed provided information on that person's background history. This personalised information is important to enable care workers to deliver care in a way that is unique and individual to that person. On a completed questionnaire form one person stated that their care plan was, "basic, does not go into details". There was no information available that showed new care workers how people would like to have their food/drink for example. On the 30 October 2014 a telephone review was conducted with one service user who was happy but stated in regards to whether they care worker were completing all the tasks in the support plan "yes, but needs changing". There was no evidence to suggest that this person's request for amendments to be made had been identified and actioned by the provider. These examples show that the provider was not able to consistently respond to people's needs.

People told us that carers were rushed to give care. One person told us that care workers had said, "I can't stay long, I'm running late". This had an impact as people were feeling hurried during their personal care visits. One person told us, "I don't blame the carers, when they are running late they can't call us, they do not have our numbers, I don't know why, but it's not their fault."

Complaints had not been effectively responded to by the provider. People who had made contact with the manager did not feel that they had been listened to. People told us "office people do not listen to my complaints". Another told us, "although they have a 12 month review, they send a list of questions to ask how we getting on with the carers; the complaints are not addressed".

The provider's complaints records showed investigations by the provider had taken place for some of the complaints recorded; however, it was unclear how this was then fed back to the complainant. It was unclear whether any learning had taken place as a result in order to improve the service and reduce the risk of similar issues happening again.

Not always investigating, responding and taking proportionate action in response to completes was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Even though people and care workers told us they thought the change of manager in December 2014 had been an improvement they still did not feel the service was well led. One person told us, "since the amalgamation, there have been some problems but they are now getting better". All felt the problems they had encountered had been about the management and systems of work which they said, "left a lot to be desired".

People were not actively involved in developing the service as feedback, when given, was never fully addressed by the provider. People told us that when they had contacted senior managers and the office, their telephone calls were not returned. On a quality assurance questionnaire for April 2015 one person wrote, "I never get follow up phone calls, promised phone calls never come".

Care workers were not receiving regular supervision to enable them to share any concerns or discuss their standard of work. They also did not know the values of the provider and what was expected of them. The provider's values included taking pride in remembering that each person was unique with individual likes, dislikes and interests. One care worker told us, "I remember being told on the induction and I know they (values) are on the office wall but I don't know them". Care workers told us they didn't feel valued or understood what their roles were. One care worker said they sought support from colleagues as they felt they were unable to communicate effectively with the provider.

There was no registered manager at the location and had not been since 2013. A senior carer had been an interim manager for a contracted three month period from January to March 2015. This contract had not been renewed however the manager continued in the position to try and assist the provider in maintaining leadership for all staff.

In March 2015 the provider identified that the service was in "crisis" due to the lack of management and the number of complaints and concerns which had been received. As a result the provider bought in a Quality Improvement Manager who had previously been involved in auditing the service to oversee the management of this location. Their role was to complete quality assurance audits, identify shortfalls in the provision of care and implement action plans to meet the identified needs. Care staff and people did not feel that they were able to communicate with the Quality Improvement Manager and were not able to raise concerns as a result.

The provider had not met the Care Quality Commissions registration requirements. They had not submitted notifications regarding reportable incidents such as safeguarding alerts. For example, we were not informed when a police investigation had commenced as a result of two allegations of theft.

The provider did not have robust quality assurance processes in place to identify issues and correctly address them to drive improvements in the service, for example in relation to monitoring and acting on missed and late calls.

Even though the provider used an electronic call monitoring system to record care workers attendance at people's homes, from the information generated it was unclear whether care had actually been delivered at the right time, by the right number of persons and for the appropriate length of time. For example, a relative told us that in one week period there had been three occasions in two days when one care worker had arrived for a double care worker visit. The computer system showed that on all three occasions two care workers had been present delivering care. However, this was not confirmed in the daily care notes where only one care worker had signed to say they were present.

The Quality Improvement Manager provided a possible explanation for the singular visits but this was not a view which was supported by care workers. One care worker told us that they had completed a number of double up care visits by themselves. This has happened "a few times with her, (the person who had complained about singular visits), and someone else". Another carer was asked how often singular care workers were required to complete double care visits, and told us, "once a day this could happen, I think I've never had a flawless day when things are just right".

The provider did not ensure that there were robust, reliable and auditable systems in place to monitor the level of service being provided to people. Care workers were also not supported as the systems in place to identify when more care workers were required were not reliable.Not

Inadequate

Is the service well-led?

ensuring that suitable systems were in place to monitor the delivery of care was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider did not ensure that care workers were able to deliver care that was person centred and able to meet people's needs appropriately.

The enforcement action we took:
The CQC were going to submit an application to cancel the registration of the location which would have prevented the provider delivering care from this branch.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider failed to ensure that people were being treated with dignity and had their privacy respected and promoted at all times.

The enforcement action we took:
The CQC were going to submit an application to cancel the registration of the location which would have prevented the provider delivering care from this branch

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Identified risks to people's health were not managed appropriately with referrals made were necessary. People were not always receiving treatment which kept them safe.

The enforcement action we took:
The CQC were going to submit an application to cancel the registration of the location which would have prevented the provider delivering care from this branch

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure that people were not exposed to a risk of harm and abuse. People were not always protected and had suffered physical harm.

The enforcement action we took:
The CQC were going to submit an application to cancel the registration of the location which would have prevented the provider delivering care from this branch

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider failed to effectively monitor, investigate and respond complaints and did not use this information to drive performance.

The enforcement action we took:
The CQC were going to submit an application to cancel the registration of the location which would have prevented the provider delivering care from this branch

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not ensure that they had robust quality assurance and data management systems in place to identify gaps in the level of care provided.

The enforcement action we took:
The CQC were going to submit an application to cancel the registration of the location which would have prevented the provider delivering care from this branch

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider failed to ensure that there were enough suitably care workers deployed in order to safely meet the needs of the people using the service.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
The CQC were going to submit an application to cancel the registration of the location which would have prevented the provider delivering care from this branch

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider did not follow robust recruitment procedures to ensure that suitably qualified and experienced care workers were employed

The enforcement action we took:
The CQC were going to submit an application to cancel the registration of the location which would have prevented the provider delivering care from this branch