Heritage Homecare Services Ltd

Nelson

Inspection report

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Ratings

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

Overall summary

We carried out an inspection of Nelson on 16, 17 & 21 September and 14 & 15 October 2015. The inspection visit on 14 October 2015 was unannounced.

Nelson provides care and support for people in the Burnley and Pendle area. The range of services provided includes, personal care, domestic help and shopping. The service provided support for older people, people with a dementia, adults with physical disabilities and learning disabilities. The agency's office is located in the centre of Nelson. At the time of the first day of the inspection the service was providing support to 135 people.

At the previous inspection on 6 February 2014 we found the service was meeting all the standards assessed.

At the time of the inspection the registered manager had left employment at the service and had applied for de-registration. 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.

Summary of findings

During this inspection we found the provider was in breach of eight regulations of the Health and Social Care Act (Regulated Activities) Regulations 2014. These were in relation to:

People had experienced missed visits and late visits which resulted in risks to their well-being, comfort and safety. Some risks to individuals had not been properly assessed and planned for, this meant appropriate action had not been taken to identify and reduce the risks to people's well-being and safety.

People's medicines were not managed appropriately, which meant there were risks they may not receive safe support.

Staffing arrangements were not properly managed to ensure people received care and support when required, in accordance with their assessed individual needs and preferences. Arrangements for staff training and supervision were not satisfactory in ensuing people employed at the service were competent and had the necessary skills and knowledge to carry out their work effectively.

Staff recruitment practices had not been properly carried out for the protection of people who used the service.

People were not provided with appropriate care and support to ensure their nutritional and hydration needs were met.

Processes for assessing, planning and reviewing people's care and choices, were not effective in responding to their individual needs and preferences.

People's concerns and complaints were not properly acknowledged, managed and responded to.

There was a lack of effective systems to consult with people on their experience of the service and to assess, monitor and improve the quality of the service provided. Records were not properly kept to make sure people's needs are effectively and safely met.

We also found a breach of one regulation of the Care Quality Commission (Registration) Regulations 2009 for non-notification of incidents. You can see what action we have asked the provider to take at the back of the full version of the report.

We found the management and leadership arrangements at the service were not effective in providing people with safe care and support.

People made some positive comments about the staff team including their attitudes and respectful manners. Staff expressed a practical awareness of promoting people's rights to privacy, dignity and independence. However, we made a recommendation about involving people in decisions about their care.

All the staff we spoke with described the action they would take if someone was not well, or if they needed medical attention.

Staff indicated an awareness of MCA 2005, including their role to uphold people's rights and monitor their capacity to make their own decisions. There were some policies around this; however we made a recommendation for improvements.

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

Summary of findings

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.

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.

People had experienced missed visits which had resulted in risks to their well-being and safety.

People were at risk of not receiving the care and support they needed as staffing arrangements were insufficient.

We found a robust recruitment procedure for new staff had not been followed.

People were not adequately protected against the risks associated with the unsafe management of medicines.

We found action had not been taken to identify and reduce the risks to people's well-being and safety.

Is the service effective?

Inadequate

The service was not effective.

People were not provided with appropriate care and support to ensure their nutritional and hydration needs were met.

People expressed mixed views on their experience of the service. Some were satisfied with the service others were not.

Staff had not received suitable training and supervision to enable them to deliver care to people to an appropriate standard.

The service was not fully meeting the requirements of the Mental Capacity Act 2005.

Is the service caring?

Requires improvement

The service was not always caring.

People made some positive comments about the caring attitude and approaches of staff. They indicated their privacy and dignity was respected. However, we were also told some carers were okay and some were not.

Care records were lacking in providing details of people's individual background histories, relationship's and cultural needs and preferences.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People were not always receiving a person centred service. The delivery of care did not meet their needs and reflect their preferences. Some people were dissatisfied with the lack of continuity in care workers.

Summary of findings

There was a lack of satisfactory arrangements to review and respond to people's changing needs and preferences.

People told us of their dissatisfaction with aspects of the service; some indicated they had raised concerns. However, we found concerns and complaints were not properly responded to and managed.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager was no longer in post. The leadership and management arrangements were insufficient in providing clear direction and effective organisation of the service.

Records did not evidence that people's care needs were safely and effectively met.

Statutory notifications had not been sent to the Care Quality Commission for recent safeguarding incidents.

There was a lack of effective processes in place to consult with people on their experience of the service. Quality monitoring arrangements were insufficient in ensuring the service was safe, effective, caring, responsive and well led.

Nelson

Detailed findings

Background to this inspection

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

Before the inspection we reviewed the information we held about the service, including notifications and previous inspection reports. We also spoke to the local authority contract monitoring team and safeguarding team. We had received several concerns about the service from various sources and we followed these up during the inspection.

This inspection started on 16 September 2015 and was announced. The provider was given 12 hours' notice of our intention to visit; this was to ensure they would be available for the inspection. The inspection was carried out by one adult social care inspector. We continued with our inspection on 14 and 15 October 2015 to gather more evidence and follow up on some further concerns that had been identified during the inspection process. This part of the inspection was carried out by two adult social care inspectors.

We used a number of different methods to help us understand the experiences of people who used the service. During the inspection we spoke with nine people who used the service and two relatives. We interviewed four support workers, three care coordinators, the training coordinator, recruitment officer and office administrator. We spoke with the designated manager, the directors, including the nominated individual and the human resources manager. We looked at a sample of records, including eight care plans and other related documentation, 11 staff recruitment records, policies and procedures, call list logs and operational records.

Inadequate

Is the service safe?

Our findings

We looked at how the service kept people safe and protected them from the risk of abuse and neglect. Prior to the inspection we reviewed the information we held about the service. There had been several matters of concern over the last six months and which had potentially impacted upon people's well-being and safety.

More recently there had been allegations of missed and late visits, which had resulted in people not receiving attention and support with their personal care and welfare needs. We were made aware of a specific incident that had resulted in harm and discomfort; this may have been prevented if carers had been in attendance. There were also concerns about the risks to people with specific medical conditions, not receiving timely and regular support with their dietary needs and medicines. At the time of the inspection, there were several safeguarding alerts which had been raised with the local authority which were under investigation. However we were told the outcome of three investigations about missed visits had been substantiated.

People we spoke with told us they had experience missed visits, their comments included: "They missed coming twice, I managed myself," "They have missed coming a few times" and "They have missed several times." All the care workers we spoke with said they were aware of visits being missed.

The service had an electronic computer based rota planning and call monitoring system. We looked at the system and found there were examples of visits being allocated to care workers which had not been completed. Office staff spoken with at the time, lacked awareness of the missed visits and could not confirm why the visits had been missed. We saw one occasion where a visit had been cancelled on the computer system for a person who used the service. We asked the provider about this and we were provided with information from the head office who dealt with the computer system. However this did not confirm who had cancelled the visit or why it had been cancelled. There was no record on the computer system to confirm the reason it had been cancelled.

We were told the call monitoring system included an audible alarm sound which would alert care coordinators of any potential missed visits, however we found during our inspection the sound had been muted on the computer monitors in the office. We were told this was because the system was monitored by another agency office within the organisation. We looked at paper records, including care plans, records of care delivery and daily visit logs, which were used for completion in people's homes. We found there were records to indicate visits had been completed, however there were also gaps which confirmed visits had not been carried out.

During the course of the inspection we found there was a lack of recognition from the providers that missed visits had occurred and the consequences for individuals had not been recognised as safeguarding issues.

The provider had failed to ensure people received care in a safe way. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the way the service deployed staff to provide safe care to meet their needs. We noted staff recruitment was ongoing. The recruitment officer described the action being taken to provide additional staff at the service. However, we found there inconsistencies in the way the service had arranged and coordinated care workers to be in attendance at people's homes, in accordance with their agreed plan of care. Care coordinators described the difficulties they had in ensuring staff were available for contracted visits. They said some staff had been reluctant to cover calls in some locations due to the travelling distance.

We asked people about their experience of the timings of staff attendance. One person indicated there had been some recent improvements to their visits. They said, "They try to arrive on time, they used to be late." However, other people told us, "They are usually late, they vary, they can get held up," "They are very much so late, they should be here at eight, but they didn't arrive until ten" and "They don't always arrive on time." One person raised concerns about their visits, they told us, "They didn't tell me they would be late, I was worrying, it was shocking." A relative described a potential risk situation should carers be late arriving to make a meal, because the person would attempt to make their own meal and would therefore be at increased risk of falling.

Some care workers spoken with told us they were not always given sufficient travelling time between visits, which

Is the service safe?

meant they were late or had to leave early. We were also given examples where they had to wait for colleges to arrive when a person was to be supported by two care workers. There was an on-call system in place during the times when staff were on duty, which meant someone could always be contacted for support and advice. One care worker told us they had lost count of the times they had to contact out of hours/on call to find out where the other carer was. A relative spoken with commented, "They do wonderfully but they are overstretched." A care worker said, "They are always pushing us to do more that we can."

The provider had not deployed sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet all the needs of people who used the service. This was a breach of Regulation 18(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the recruitment procedures protected people who used the service and ensured staff were of good character and had the necessary skills and experience. Staff spoken with indicated the required checks had been carried out prior to them starting. The service had defined policies and procedures to underpin and direct the recruitment of new staff. However we found the procedures had not been consistently followed. We looked at the recruitment records of 13 members of staff employed by the provider. We found some of the required checks had been completed before staff worked for the service and these were recorded. The checks included proof of identification checks and information to show the applicants physical or mental health conditions had been sought and reviewed. However we identified some concerns that related to safe recruitment. For example we found there had been occasions where staff had carried out visits to people's homes prior to obtaining a DBS (Disclosure and Barring Service) check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. There were no records to show the risks around employees working without DBS clearance had been assessed and mitigated.

The recruitment process included applicants completing a written application form and attending a face to face interview. We identified concerns relating to this part of the recruitment process. This was because records relating to the interview were brief and contained limited information about the suitability of the staff. There was a lack of specific information to explain why the applicant's previous employment had ended. Written references had not always been obtained on the applicants conduct and character and this had included where they had previously worked in a care setting. Some recruitment records only included one reference. We noted one reference was from a relative which may not provide an unbiased view. We found full employment histories had not always been obtained and gaps in employment had not been pursued and clarified. We saw that several files had been checked and some of the discrepancies in the recruitment processes identified, however we would expect safe recruitment practices to have been consistently carried out.

This meant the provider had not operated robust recruitment procedures to ensure applicants were of good character and had the necessary skills and qualifications. This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the way the service managed risks to individuals. Care workers spoken with had an awareness of people's environmental risk assessments. They described the action they would take in the event of accidents and emergency situations. Although reference was made to the health and safety policy in the employee hand book, instructions for responding to accidents, emergencies or untoward events were not included. This meant care workers did not have direct ongoing access to the service's accident and emergency procedures.

Records were available to show health and safety risk assessments had been completed on environmental matters in people's homes. However these were brief and lacked clear direction for staff where specific environmental risks had been identified. Records indicated reviews on the environment had not been completed regularly to ensure staff had access to up to date information to guide them.

Processes were not in place to identify, assess and manage risks to people's individual care needs. For example there were no risk assessments in place that gave specific information to guide staff such as diet and nutrition, skin care, medicine management, or behaviours. We found there were entries in care records which stated people were, 'at risk of falls' however risk assessments had not been carried out to proactively identify the risk and there were no directions for staff to follow to minimize the risks. We also saw in a care file that a person needed the use of a

Is the service safe?

wheelchair to aid their mobility. However we could not see evidence that a risk assessment had been completed for staff to effectively manage the risk, other than guidance on the action to take if the wheelchair became faulty.

We noted there was a section in the care plan records headed 'contingency plan' which made reference to responding to emergencies and other circumstances, but we found these included minimal information or had not been completed.

This meant the provider did not have suitable arrangements in place for assessing and managing risks to people's health, safety and welfare. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the way the service supported people with their medicines. People who received assistance with medicines, told us support was appropriately provided. One person commented, "They get my medication from the pack, they give it on time." The service had policies and procedures to underpin and guide medicine management. However, we noted there was no information on medicine management in the employee handbook. This meant care workers did not have access to relevant guidance on the safe administration of medicines.

We saw there were discrepancies in the way people's medicines were recorded and managed. It was not always clear in individual records, what level of support staff were expected to provide in response to people's needs and preferences. There was some conflicting information in care records, for example we noted one section of a care plan stated the person 'self-medicates' yet another instruction was 'prompt with medication.'

Medicine administration records (MAR) were brief and did not contain information about the type, dose, frequency of medicine as well as the route of administration. We saw abbreviations were being used, but there was no key code to clarify their meaning. There was also no scope for care workers to record the reason for gaps in people's MAR so that patterns of missed medication could be monitored. Detailed and accurate records were not kept to demonstrate, the safe administration of each prescribed item. Therefore it was not clear if medicines were being administered accurately in accordance with the prescribed instructions. The provider showed us a copy of the proposed MAR chart; however this was yet to be introduced.

There were written entries in care notes of staff applying topical creams on people using the service, however we could not see evidence these had been recorded or prescribed on the MAR chart. Care files we looked at had no evidence to provide instruction for staff in applying the creams and did not include body maps to guide staff on where to apply them. This would mean people were at risk of unsafe and unrecorded medicine administration.

Staff told us they had completed on-line safe handling of medicines training and there were records to show most had completed this training. However, there were no processes in place to assess and monitor staff competence in providing safe support with medicines following their initial training, or as part of an annual review.

This meant the provider did not have suitable arrangements in place for the proper and safe management of medicines. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with made some positive comments about the service and the attitude of staff. Their remarks included, "I feel safe with them," "They are nice people to a degree" and "No shouting or bad language."

Staff spoken with expressed an understanding of safeguarding and protection matters. They were aware of the various signs and indicators of abuse. They were clear about what action they would take if they witnessed or suspected any abusive practice. Staff said they had received on line training on safeguarding and protecting adults. There were policies and procedures available at the agency office which provided direction on identifying and managing safeguarding matters. However, we noted the employee hand book did not include a summary of the safeguarding procedures or the contact numbers of the local authority, should a safeguarding alert need to be made. This meant staff did not have access to information on keeping people safe and raising safeguarding alerts in accordance with local safeguarding protocols.

Inadequate

Is the service effective?

Our findings

People we spoke with indicated some satisfaction with the service provided from Nelson. One person told us, "Things are okay" and a relative said, "You couldn't better them, they always see to things, they do their very best." However, people also indicated the service was not always effective. For example one person said, "They are not consistently good, I'm not very happy with them."

We looked at how the service trained and supported their staff. We asked people who used the service for their views on staff abilities. One person said, "I don't think they are all trained well, they don't have a great deal of knowledge."

We found there were inconsistencies in the way staff training was managed and delivered. During the course of the inspection we observed newly recruited staff members accessing in the service's e-learning training programmes as part of their induction process. Care workers spoken with told us that they had received induction training when the commenced employment with the service. We found records in support of this training were kept on most of the staff files we looked at. However, we found there were several examples where the staff induction checklist training and shadowing programme had not been fully completed. This meant it was not clear the providers had satisfied themselves that new employees were sufficiently competent to carry out their duties prior to working in the community.

A process was in place to inform staff of service's policies and procedures. This involved the completion of a checklist, to confirm they had read and understood the policies. However, we found examples where new staff had not completed this process, which meant they may not be fully aware of the operational guidelines of the service and their expected role and responsibilities.

We spoke with the provider's training coordinator who indicated progress was being made with the staff training programme and that the training budget was sufficient. We were told arrangements were being made for eight new employees to complete the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers adhere to in their daily working life. We noted Care Certificate induction packs were available for use at the office base. One care worker told us they had been made aware of the introduction of the Care Certificate induction.

We looked at the staff training matrix record and although this showed training was ongoing, we found there were some gaps in the training. Such as some staff had not had recent refresher training in key areas such as first aid awareness and health and safety. We also noted several care workers who had been at the service for more than two years had not been supported to attain recognised qualifications in health and social care. The training coordinator confirmed short course training sessions were held at the service and further training was being arranged. We were told staff training was to be provided for staff on appropriate record keeping. However, we were told some care works were reluctant to do e-learning and that the previous week 10 staff did not attend an enrolment session for a recognised qualification in health and social care.

We found little evidence of senior staff supervising and monitoring staff competence in carrying out their role. Two staff spoken with told us they had previously had a one to one supervisions, and 'spot checks' on their work in the community. However, records were not available to show there was a programme of ongoing one to one supervisions at the service. One member of staff told us that they had not had a one to one session with the management to discuss their performance or training needs since commencing employment in February 2015. The provider showed us a new format which was to be used for one to one support meetings, but this had not been introduced.

This meant the provider had not ensured staff received appropriate training and supervision to enable them to carry out their duties. This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Not all the people we spoke with received support with food and drink. Care workers spoken with described the support provided with food and drinks. This included some meal preparation, including breakfasts and help with ready-meals which they heated in the microwave oven. They said they had received training on basic food hygiene. Staff indicated that if there were any concerns about a person's food and fluid intake they would contact the agency office. People's support needs in relation to food and drinks were briefly noted in their care records. We

Is the service effective?

found there was a lack of information about dietary requirements, nutritional needs and people's food and drink preferences, likes and dislikes. There were no risk assessments on people's nutritional needs. Staff monitored and recorded what people had eaten and drank on specific recording charts. However we noted these were not always completed. We found the provision of effective support with food and drink had been influenced by missed calls and late visits. This had resulted in a person missing meals and people with specific medical conditions, not receiving timely and regular support with their dietary needs and medicines.

This meant the provider had not ensured people's nutritional and hydration needs were met. This was a breach of Regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The MCA 2005 (Mental Capacity Act 2005) sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. We found arrangements had been made for staff to receive training on this topic. Staff indicated an awareness of MCA 2005, including their role to uphold people's rights and monitor their capacity to make their own decisions. The service had a policy about consent, which made reference to the principles of the MCA 2005. However the policy was not specific around the procedures to follow should a person lack capacity to make their own choices and decisions, in accordance

with the requirements of the Mental Capacity Act 2005 and associated code of practice.

We found specific mental capacity screening assessments had not been carried out with individuals. This meant effective consideration may not have been given to people's capacity to make particular decisions and the kind of support they might need to help them make them. People spoken with told us the care workers consulted with them about their care and support needs. We received the following comments, "They ask me, and do the things I ask for" and "They ask me what I want." People indicated they had agreed to the support and care provided by the service. The care plan records we looked at showed people had been involved and consulted about various decisions and we found they had signed in agreement with them.

People using the service and their relatives told us that most of their health care appointments and health care needs were co-ordinated by themselves. People's care records included contact details of relevant health care professionals, including their GP, so staff could contact them if they had concerns about a person's health. One person commented, "They are on the ball when (my relative) is not well." The staff spoken with said they monitored people's health and wellbeing. They described the action they would take if someone was not well, or if they needed medical attention. One relative said, "They keep in touch with me." However we found people's medical histories had not always been included in their care records, which meant care workers may not always be aware of any underlying health care conditions.

We recommend the service consider the relevant guidance and principles contained in the code of practice for the Mental Capacity Act 2005 and take action to update their practice accordingly.

Requires improvement

Is the service caring?

Our findings

People we spoke with expressed mixed views about the staff team and the care and support they received from the service. A relative said, "I know most of the carers, they are golden hearted." However, other comments included, "They are usually alright, some don't talk much, they want to be away" and "The people they send, some are okay, some are not."

We received some positive comments about the staff attitudes people said, "They are nice, very pleasant" and "They are respectful." One relative remarked, "They are respectful, they treat her like a lady." One person told us, "I have more or less the same people," another said, "I have one or two regulars."

People indicated their privacy needs were upheld and that care workers were respectful of their homes and property. Care workers spoken with explained how they promoted people's individual privacy. One told us, "I always knock on (on the door) I never just walk in." They gave examples of how they maintained people's dignity and respect when providing support with personal care. Care workers described their understanding of person centred care; they told us how they aimed to promote independence in response to people's individual needs and preferences. They said they had completed e-learning around the promotion of equality and diversity. They said they were aware of the content of people's care plans, risk assessments and care records.

We noted the care assessment process provided scope for details to be obtained and recorded on key matters that were important to the person. This included leisure interests, previous employment, relationships, cultural needs and religion. There were sections in the care plan layout headed, 'important details and personal preferences you want others to know.' This would help people to express their views and be involved in decisions about their care and support. However we noted information in most of the care files we looked at was brief or had not been fully completed in these sections. This indicated people's holistic needs and choices had not been fully considered.

There was a guide available for people who used the service which included key contact details, the range of services provided and the arrangements for the delivery of service. The guide also provided information on the service's care philosophy, visions and values. Mention was made of improving people's quality of life and maintaining independence. The guide included the contact details of local advocacy services. Advocates are independent from the service and provide people with support to enable them to make informed decisions.

The guide also included contact details of other local health and social care organisations, who people could contact for additional assistance. Some people spoken with indicated they had received a copy of the guide and were aware of its contents. One person told us, "There is information available in the guide." On reviewing the guide we noted some of the information was in need of updating, for example in relation to the registered manager and some incorrect references to the name of the Commission. The service had an internet website which provided further information about the services available.

We recommend that the service seek advice and guidance from a reputable source, about supporting people to express their views and involving them in decisions about their care and support.

Requires improvement

Is the service responsive?

Our findings

Some people spoken with indicated the service was responsive to their needs and they appreciated the support provided by staff. One person told us, "They do what I want them to do," another commented, "They ask if anything else needs doing." We were also told, "The carers never did anything before, they are very good now." However, some people expressed a dissatisfaction with the lack of continuity of care workers, two comments were, "They make changes to staff, but I'm not made aware" and "They are alright generally, but I am not happy with strangers." Another person explained, "They are respectful, very nice, but I don't know who is coming, I haven't had a rota for two weeks."

We looked at the way the service assessed and planned for people's needs, choices and abilities. Arrangements were made to meet with people to carry out to the initial assessments and discuss their care requirements. However, the provider also said they would deliver a service to people straight away without carrying out an assessment, with aim of completing an assessment within 48 hours. This could mean care workers would be delivering a service without having information about people's individual needs.

People spoken with said, "They came from the office at the beginning," "They went through things" and "They did an assessment, they wrote it down." We looked at people's care files which included records of their initial assessment carried out by the service. Some care files also included assessment information provided by the local authority. The service's assessment records were combined with and part of, the ongoing care planning process.

Most of the assessment records we looked at were brief and lacking in detail. The areas of needs considered included, mobility, toileting, sensory needs, mental health and respiration. The assessment process included a tick box indicator, under areas of identified need. For example in relation to sensory needs the options to tick were, 'speech,' 'sight' and 'hearing'. We found some of the sections of the assessment forms had not been fully completed, or the required information had been omitted altogether. An example being the person's medical history had not been considered. This indicated people's individual needs had not been properly assessed with them, to ensure their identified needs were planned for and responded to.

We found each person had an individual care plan which was developed from their assessment. However most were brief and lacked detail in how to effectively care for people's individual needs. People spoken with had some awareness of their care plans, one person told us, "It's written down what they will do," another said "They write in the care plan." However, we found care plans were lacking in specific instructions for care workers to follow. Examples of this included, 'assist out of bed,' and 'assist with personal care.' One person using the service commented, "They never seem to know what to do unless I tell them." We also noted an example where a specific need, which was referred to in a person's local authority assessment had not been included in the care plan process. This meant there was a risk their needs would not be monitored and responded to.

Care workers indicated they regularly looked at the information in care plan records, one commented, "I always check everything." However, the lack of information meant care workers were not properly instructed to effectively meet people's needs. We were also told by a care worker that one person who used the service did not have a care plan in place for more than ten weeks.

We were told the aim of the service was to review people's care and support needs every six months or more frequently in response to people's changing needs. However we found this timescale had not been consistently adhered to. We noted some people had not had a review for almost 12 months. We also looked at one care record which indicated a review had been completed, but there was no information to show what matters had been considered, or if the person had been involved with the review.

Processes were in place for diary records of the care and support provided to people to be completed by care workers during each visit. This should promote good communication and enable care workers to monitor and appropriately respond to any changes in a person's needs and well-being. However, the records were we looked were not always effectively kept to provide consistent and accurate details of people's individual well-being or the care and support delivered to them.

Requires improvement

Is the service responsive?

This meant the provider did not have suitable arrangements in place for planning people's care and support, in a way that meets their individual needs and preferences. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection the provider acknowledged that care plan processes had not been reviewed for some time and gave an indication that action was to be taken in respect of this matter.

We looked at the way the service managed and responded to any concerns or complaints. Most of the people who used the service expressed an awareness of the service's complaints procedure and processes. They made the following comments, "I would contact the office if I had a complaint" and "I would inform the management if I wasn't happy."

We looked at the compliments and complaints procedure which had been included in the guide to the service. This described the approach and assurances around encouraging people to voice their concerns in order to make improvements. The service's contact details were included and reference was made to other agencies that may provide support with complaints. However, the procedure did not specify how the complaint would be managed and responded to, or the expected time-scales for the investigation and response. There was a service user complaints procedure on the policy file at the agency office. This described in more detail how complaints should be made and the various stages of the complaints process with time scales. However it was not evident the procedure had been shared with people who used the service or their relatives.

There were no additional policies and procedures for managers and staff, to provide direction on receiving, managing, investigating and responding to complaints or concerns. This would mean the management of complaints may not be consistently responded to and managed.

During the inspection we received several comments of dissatisfaction with various aspects of the service, in particular about missed and late visits. Some people told us they had contacted the service to raise their concerns. One person said, "I have complained, they said sorry" another said, "My son complained." However, we were told there had not been any been any recent complaints and there had been only one complaint logged and processed in the last 12 months. We looked at the service's complaints file and found there was a copy of letter sent to the complainant. But there was no evidence of the original complaint made, or a log of the actions taken to investigate and manage the compliant, or the actions taken to make improvements. We found there were no systems in place for the management of 'soft information' such as minor concerns, or grumbles. This meant complaints and concerns had not be identified, taken seriously and responded to proactively.

The provider did not have suitable arrangements in place for receiving and acting on complaints to ensure they are effectively investigated and any necessary action taken. This 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

We asked people about their overall view of the service, two comments from people who used the service were, "There is a need for improvement" and "It's improving." Staff comments included, "It's okay" and "It's getting better."

We looked at how the service monitored quality. Prior to the inspection we received some information that related to people experiencing missed and late visits. The provider said they were not aware of any missed visits without some interventions from the agency. The service had an electronic computer based call monitoring system. This included a visit logging system, care workers were to ring a number to log in on arriving and when leaving a person's home. This would enable office staff to monitor if visits were taking place, at the correct time and for the required duration. We found the call monitoring system was not being effectively checked an audited for late and missed and late visits, to ensure people received safe and consistent care. On the second day of the inspection we asked for assurances that action would be taken to ensure the system was effectively monitored and managed to mitigate risks to people using the service. The person in charge devised and implemented a contingency protocol to address these matters. However we would have expected these issues to have been identified and acted upon without our intervention. We asked for a copy of the contingency protocol to be sent to the Commission; however this was not received at the time of writing the report.

We were told some action had been taken to audit care plan process, however there were no records to support this action. We found some of the staff files we looked at had been checked and there were notes completed about the missing information. However it was not clear what action was being taken to resolve the identified issues.

We looked at the service's quality monitoring file. We found there had not been any observational 'spot checks' on care workers competency or their conduct when they were delivering care and support, since August 2015. However, on the last day of our visit to the service, we were advised one spot check had subsequently been carried out. At the start of the inspection we were told there had not been any satisfaction surveys people who used the service in the last 12 months, that these were due to be sent out in September 2015. We checked the progress of this consultation process and found three people had been contacted for their views and opinions by telephone on 6 October 2015.

At this inspection we found staff recruitment practices did not ensure the proper checks were carried out before they worked at the service. The management of medicines was lacking in ensuring people were safely and effectively supported. Concerns and complaints were not proactively recognised, investigated and dealt with. Risks to individual's had not been effectively assessed and managed and care plans were lacking in sufficient detail to respond to people's needs. There was also a lack of appropriate staff deployment, training and supervision. This indicated there was lack of effective processes in place to asses, monitor and improve the quality and safety of the services provided.

The provider did not have suitable systems or processes in place, to ensure the service is operated effectively. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there were shortfalls in record keeping. For instance care plans were lacking in details about people's needs and some risk assessments were incomplete. There was a lack of appropriate records in relation to medicines, including dosage instructions and administration. Appropriate records had not been kept of complaints processes or the management of safeguarding alerts. Staff recruitment records were incomplete. We found there were gaps in some records, contemporaneous notes had not always been made and some entries had not been dated. We were told some of the paperwork had gone missing from the service. We noted an accumulation of completed individual records from people's homes had been left in a disorganised way at the agency office.

Some of the people who used the service told us they received support with shopping and errands. Care workers spoken with confirmed they provided this type of support. We checked care files to see if appropriate records were kept in support of these arrangements. We found there was a lack of appropriate recording systems in place to support the safe, accountable management of people's monies.

Inadequate

Is the service well-led?

The provider had not always maintained accurate and complete records relating to people who used the service, people employed at the service and management of the service. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider is required to send the CQC notifications of incidents which affect the safety and wellbeing of people using the service. We found there had been several occasions when safeguarding alerts had been made, which required a notification to CQC. Our records indicated we had not received such notifications, despite discussing these matters with the provider during the course of the inspection. Notifying the CQC of incidents which affect the health and welfare of people who use the service enables us to check with the provider how these are being dealt with. It also alerts us to any emerging patterns or trends as part of our monitoring of the service.

The provider had failed to notify the commission of safeguarding incidents at the service. This was a breach of Regulations 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

The registered manager left the service several weeks before the inspection along with three office based staff. The provider told us arrangements were being made for another manager to be recruited and registered with the Commission. We asked staff for their views on the current leadership and management arrangements at the service and they expressed varied opinions. We received the following comments, “Things are okay” and “The managers are approachable.” However we were also told here was a lack of effective communication at the service and lines of accountably were unclear. One staff member told us, “I’m not sure who the manager is at present.” Another member of staff told us of a situation which they had reported at the agency office. They told us they were unsure who to report the matter to. They said they had asked who the manager was and were told they didn’t need to know.

We discussed the concerns we had identified during our inspection with the provider, we were told they had been ‘firefighting’ since the manager had left service. However we were not confident the seriousness of the concerns were fully acknowledged by the provider.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to ensure people received care in a safe way. (Regulation 12(1))

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet all the needs of people who used the service. (Regulation 18(1))

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider failed to operate robust recruitment procedures to ensure applicants were of good character and had the necessary skills and qualifications. (Regulation 19 (1)(2)(3))

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to have suitable arrangements in place for assessing and managing risks to people's health, safety and welfare. (Regulation 12(2)(a))

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Enforcement actions

	The provider had failed to have suitable arrangements in place for the proper and safe management of medicines. (Regulation 12(2)(g))

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had failed to ensure staff received appropriate training and supervision to enable them to carry out their duties. (Regulation 18 (2)(a))

Regulated activity	Regulation
Personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The provider had failed to ensure people's nutritional and hydration needs were met. (Regulation 14 (1) (b))

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider had failed to have suitable arrangements in place for assessing and planning people's care and support, in a way that meets their individual needs and preferences. (Regulation 9 (1) (3) (b))

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider had failed to have suitable arrangements in place for receiving and acting on complaints to ensure they are effectively investigated and any necessary action taken. This was a breach of (Regulation 16 (1)(2))

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had failed to ensure there were effective systems in place to assess, monitor and improve the quality and safety of the service. (Regulation 17 (1) (2))

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had failed to maintain accurate and complete records relating to people who used the service, people employed at the service and management of the service. (Regulation 17 (1) (2) (c)(d))