Vincentian Care Plus

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Vincentian Care Plus is a domiciliary care agency that provides care and support to people living in their own homes. At the time of the inspection there were 141 people using the service.

This inspection took place on 11 and 14 August 2017 and was announced. We told the registered manager 48 hours before the inspection that we would be visiting. This was to ensure the registered manager would be available to take part in the inspection.

At the previous comprehensive inspection on 14 and 15 July 2016 we identified breaches of regulations in regards to person centred care, safe care and treatment, good governance, staffing and notifications. We made one recommendation in relation to medicines management. We rated Vincentian Care Plus as requires improvement overall. We asked the registered provider to send us a plan to tell us what they would do to meet legal requirements. The plan detailed what actions the registered manager and staff would take to meet legal requirements. You can read the report from our last inspection, by selecting the 'all reports' link for Vincentian Care Plus on our website at www.cqc.org.uk.

At this inspection we followed up on the breaches of regulations to see if the registered provider had made improvements to the service. We found that the registered provider had taken some action to meet the regulations. The improvements we found were in relation to staffing and notifications.

The service had a registered manager. 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.

We found people were at risk because the service did not have effective systems in place to manage missed and late visits. During and after the inspection we requested a log of missed and late visits but at the time of writing this report this was not received as requested. There was a system for people using the service and staff to contact a manager outside of regular office hours. However, people using the service and staff said that their call was not always answered when they contacted the out of hours telephone number.

People were at risk of not receiving their medicines safely because there were not effective systems in place to monitor and audit medicine administration. The registered manager did not have systems in place to ensure that people had their medicines as prescribed in a safe way.

The service did not have effective systems in place to ensure that care records were accurate and up to date. We found that people's care records contained gaps in them and were not always updated. People had an assessment of their needs before using the service. Care reviews of people's health care needs were completed on a regular basis. However we found following a review, people's care plans were not updated to reflect changes in need or level of service. This meant that people's care records did not always reflect

their current needs.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible. The registered manager and staff did not understand the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Records showed that a person's medicine was hidden within their home and appropriate steps had not been taken to assess their capacity to make this decision and to ensure that the decision was made in their best interests.

People had the opportunity to provide feedback about the service. People provided mixed views about the service and the quality of the care they received. The registered manager had not taken action to manage the concerns raised by people.

People said that their regular care worker was caring and understood their needs. They commented that they were treated with dignity and their privacy respected when they were receiving care and support.

Risks to people's health and wellbeing were assessed. There was a plan in place for the identified risks and guidance for staff to manage them. Staff understood the registered provider's safeguarding procedures and knew what action to take if a person using the service was at risk of abuse or harm.

People were supported by health care services. When people's care and support needs changed staff sought appropriate advice from health and social care professionals.

People gave their consent to the care and support provided. A relative gave consent on behalf of their relative if they were unable where they had the legal authority to do this.

There were effective systems in place for people to make a complaint. The registered manager dealt with complaints about the service. We saw records that showed the registered manager had acted on complaints and responded appropriately.

People had meals that supported their requirements and personal choices and preferences. Staff completed shopping and meal preparation for people as required.

Staff had support from the registered manager. Staff completed an induction, supervision, training and appraisals on a regular basis. Staff had the opportunity to discuss their personal and professional development needs. These were recorded and the registered manager supported staff to achieve self-identified goals.

The registered provider ensured there were enough staff deployed. This ensured people received their care and support from a member of the care team as required and in line with the care assessment. The registered provider followed robust recruitment processes. This ensured suitable staff were employed to provide care and support to people.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made

significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

We identified continued breaches of regulations in regards to person centred care, safe care and treatment, and good governance. We are considering what further action we are going to take. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 service did not have effective systems in place to manage missed calls and late visits safely. The out of hours system was not always effective. This placed people at risk of harm in an emergency because staff were not always available to respond.

People may not have always received their medicines safely because there were not effective systems in place to monitor and audit medicine administration.

Staff understood the registered providers safeguarding policies and procedures.

Risks to people were assessed and management plans put in place to mitigate those risks.

Is the service effective?

Requires Improvement

The service was not always effective. People were not always cared for in line with the Mental Capacity Act 2005.

Staff completed training to support them in their caring role.

Regular supervision and appraisals took place for staff, this enabled them to identify and develop goals for their personal development.

People were supported by staff to eat sufficient food and drink.

Is the service caring?

Requires Improvement

The service was not always caring. People commented that they had frequent changes in care staff which meant their care lacked continuity. People said that their regular care workers were caring and understood their needs. They said they were treated with dignity and their privacy was respected when they were receiving care and support.

Staff supported people so they could remain as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs. People had an assessment of their needs and regular reviews of their care. However we found that people's care plans were not updated to reflect changes in care and support.

Volunteers from the service visited people in their homes and provided friendship and companionship.

The service had a system in place for people to make a complaint about the care and support they received.

Is the service well-led?

Inadequate

The service was not well led. People and staff raised their concerns about the management of the service and the effectiveness of the management team. The registered manager did not have an effective system in place to ensure aspects of the service were regularly monitored and audited.

The service did not have effective systems in place to ensure the quality of records were accurate.

The registered manager sent appropriate notifications to the CQC as required.

Vincentian Care Plus

Detailed findings

Background to this inspection

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

This inspection took place on 11 and 14 August 2017. The first day of our inspection was unannounced. We let the registered manager know that we would be returning to the service on a second day to complete our inspection. This inspection was carried out by two inspectors and two Experts by Experience. 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 information about the service we held, including notifications. A notification is information about important events, which the service is required to send us by law. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also asked the registered manager for an updated contact list of people who use the service and professionals involved with people who use the service.

We spoke with 13 people using the service, five relatives and 12 members of care staff. We also spoke with the registered manager, care consultant, volunteer coordinator and human resources manager. We received feedback from two members of the local authority's team to get their views on the service. We used this feedback to help inform our judgements.

We also considered information of concern we received which had been shared with us by the local authority.

Inadequate

Is the service safe?

Our findings

At the last inspection in July 2016 we found that the provider had breached the regulations we inspected. The registered manager did not ensure people received a service that was safe. People did not have regular care reviews or updated risk assessments which demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Financial transaction sheets were not always completed which meant that people were vulnerable to the risk of financial abuse. Missed calls and medicines were not managed safely. We recommended the provider take into account 'The handling of medicines in social care' by the Royal Pharmaceutical society. This demonstrated breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In addition we found staff at the service failed to notify the CQC of serious incidents and safeguarding concerns in accordance with their registration requirements which demonstrated breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found that the provider had made some improvements. However, we found continued breaches in relation to the management of risks to people's safety associated with missed and late visits and with the management of medicines.

People told us that they felt safe with the care staff. People shared their comments about their safety, they told us, "Absolutely", and "Oh yes, I feel very safe". Another person said "Absolutely safe" and another person said "Oh, yes, perfectly safe with them [care workers]." However, despite these positive comments we found that people were not always safe because systems in place did not always protect people from harm.

The registered manager continued to fail to manage and mitigate risks to people resulting from missed and late visits. During the inspection we asked the registered manager to explain to us how they managed and mitigated the risks associated with missed and late visits. They told us that all missed visits were raised with the local authority as a safeguarding concern. We looked at the safeguarding service users from abuse policy. It did not state that missed visits were to be raised as a safeguarding concern with the local authority. There was no list of late visits available because these were not recorded. The registered manager told us that they would have to check their computer system to identify individual late visits. We found that this system did not protect people from the risk of a late visit because the numbers of late visits was unknown and there was no system in place to monitor, report or act on this to ensure people received their care as planned.

We were concerned about this so we requested further details about the investigation and management of missed and late visits. After the inspection we asked the registered manager to send us copies of all missed and late visits. We did not receive the information as requested.

People gave us mixed views on the promptness of their care visits and the reliability of the service. People told us that they had experienced missed and late visits since receiving care from the service. One person said, "Sometimes not [told about missed or late visits], there seems no logic in arrangements and care workers are not happy", another commented "But don't always get through to the office or they don't

respond" and a third told us, "Mostly – when they don't, they can't help it being late." However another person told us "They are never on time. Today the care worker turned up an hour late, at 11am rather than 10am." Another told us that the care worker did not spend the allocated time with them, they told us, "The care worker always left after 40-45 minutes, presumably to get to [the] next appointment on time." A relative said "They only sometimes turn up on time." One care worker showed us her rota on their mobile phone and it was clear that the provider did not give staff travel time between appointments. We were concerned about the feedback on missed and late visits and requested records of all missed and late visits that had occurred in the last six months. We did not receive all the information as requested. Therefore we could not be assured that people were receiving their care as planned or that people were being protected from the risks of harm associated with this. We notified the local authority of these concerns.

There were enough staff who had been safely recruited to meet people's needs. However, we looked at the staff rotas for the four weeks prior to the inspection and noted that on six occasions staff were not provided with sufficient time to travel between people they were providing care for. People we spoke with told us "One care worker ran half an hour late, but phoned me" another said "More often than not, on the odd occasion the care worker goes to another person and management do not tell me, and care worker will be one hour late." We spoke with staff and they raised concerns about the time allowed to travel between care visits. Staff made comments such as, "Promised a year ago to set up a template to have set clients. All that changed. I started having gaps in my rota. They're not giving me enough hours, because they are using agency staff. There are real issues around people getting proper care if the hours are squeezed in" and "It's not fair. If clients are all in one area that's okay" and "The time allocated makes it impossible to cross from North to South, we are the losers" and "We have been repeating this for a year now…It's not fair." One member of staff told us "I'm usually on time for visits as given 10 – 15 minutes travel time between visits." However, other staff raised their concerns with us about their lateness due to the lack of travelling time available. This showed that care workers did not always have sufficient time for travel between visits which meant that people were at risk of late and missed visits impacting on their health and well- being.

People were not always supported by staff in the event of an emergency. The service had an out of hours number. Staff and people using the service had an out of hours contact number that they could use to speak with a senior member of staff when required from 5pm to 10pm each week night and on the weekends. Records showed that people had some difficulty in contacting the out of hours numbers when they needed this. One person told us "When we phoned the company's out of hours number, no one answered." Another person told us they contacted the out of hours telephone number because the care worker did not arrive for their visit the Saturday prior to our inspection. When they called the out of hours telephone number their call was not answered and their relative had to support them with care at that time. A second person told us they had experienced a missed visit and they were not notified of this before the expected time of the visit. One member of staff said there was "no one to answer the phone. I was not able to leave messages because they said they did not know who would follow up their concerns. Another said, "They don't consider the distance. They don't know the needs of our patients. There is no continuity of care." This meant that people were at risk of not receiving care and support that they required to maintain their health and well-being.

People continued to receive their medicines managed in a way that was not safe. The registered provider's medicine policy stated that staff prompted people with their medicines. These medicines were dispensed in a blister pack or in boxes. The registered manager confirmed and records showed that staff did not administer medicines to people. However, care logs for one person showed that staff had administered eye drops to a person. This meant that staff did not follow the registered provider's medicine management policy.

We found that the registered provider did not follow good practice guidance from the Royal Pharmaceutical

Society. This guidance recommends that the names of medicines should be attached to or written on each medicine administration record sheet (MAR) and on each person's care record as good practice. We found this did not routinely happen. We found one person did not have details of medicines on their care record. This meant that staff may not have been aware of what medicines they were prompting people to take and therefore would not identify side effects associated with taking these medicines. This meant that office based staff were also unable to review whether people received their prescribed medicines safely. People were placed at risk of receiving inappropriate treatment because MAR charts were not always in place. This increased the risk of medicine administration errors, affecting people's health and well-being.

The provider had a system in place to complete audits of medicine management. We asked the registered manager for a copy of a medicine audit. They told us that there was no audit report available because staff did not complete one. The registered manager explained office based staff checked the care workers entries to monitor medicines management. However we found that care logs did not always reflect how staff supported people with their medicines. For example, a person's care plan stated they should be prompted with medicines once a day. But their care logs sheet recorded staff prompted medicines twice a day. Another example showed a care worker administered eye drops three times a day. However the medicines policy stated and staff confirmed that they did not administer medicines. From the medicine management records we saw the registered manager could not be assured that people's medicines were delivered and administered in a safe way. We found that the systems to audit medicines were not effective because the medicine administration records were not accurate. Staff did not complete a medicine audit report and were therefore unable to share good practice or areas of improvement with staff. One relative told us of an incident where their family member's medicines were not stored safely. We were concerned about this information and as a result we raised a safeguarding alert with the local authority because we found that staff did not always manage people's medicines appropriately and safely.

The eight paragraphs above demonstrate a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a safeguarding policy and process in place which gave guidance to care staff about how to keep people safe from harm and abuse. The policy contained details of the possible signs of abuse. It also detailed staff's safeguarding responsibilities including how to protect people from abuse and the action to take if they had any concerns about a person's safety. Staff we spoke with understood the different types of abuse, the signs to look out for and how they would report abuse. One member of staff told us, "We have to look after clients and safeguard their safety." Another member of staff said, "We have to be careful, if we have any concerns about people, I would call the manager and the police."

Staff employed at the service were safely recruited. The registered manager arranged for pre-employment checks to be carried out. Staff records contained copies of their proof of address, confirmation of visa requirements, at least two reference checks from previous employers, explanations for gaps in their work history and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups, by disclosing information about any previous convictions a person may have. Safe recruitment practices were followed to ensure suitable people were employed by the service.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in July 2016 we asked the provider to take action to make improvements in relation to staff training and support. We found that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the registered manager had taken action to meet this breach of regulations.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People gave staff their consent to care. Care records and documents were signed by people or their relative when required. During care visits people told us staff obtained consent from people or their relative when meeting their needs. One person said "yes [staff] ask me if they can help me before doing so." However, we found on one occasion a person was not cared for in line with the MCA. Care records showed that their medicines were hidden from them within their home. The person's care records contained information that showed that dossette boxes were being hidden. We checked the person's care records for further details. The care records did not contain an assessment in line with the requirements of the MCA or a Court of Protection document that described why staff were hiding their medicines. We found that registered provider did not record clearly on their care records why medicines were hidden from the person. This demonstrated that the registered manager did not understand their role and responsibilities to care for people who may lack decision making capacity. Therefore we could not be assured that this person's rights were being protected. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that people were cared for in a way that protected them from risks from the unlawful deprivation of their liberty.

Staff received an induction, training, appraisal, and supervision to support them to carry out their roles effectively. Each new member of staff had completed a period of induction. The induction supported staff with training and enabled them to shadow experienced members of staff. One member of staff told us they had completed a two day induction which included training in health and safety, moving and handling, safeguarding adults and medicines management. The induction process allowed new members of staff to become familiar with working with people using the service and the provider's policies and procedures.

Staff underwent training to equip them for their role. We saw the training matrix that showed staff had completed training in health and safety, moving and handling, safeguarding adults and medicines

management. Staff also had the opportunity to complete updated training as required. Staff told us that they enjoyed the training they had completed at the service. One member of staff said "[The training] was very helpful and very useful." Another member of staff said they "learnt about medicines, delivering personal care, showed how to use a hoist, food hygiene, conduct and codes of practice." This meant that staff were trained in a way that helped them support people effectively.

Staff had regular supervisions with their manager to discuss their role and any concerns. In the staff files we looked at we found supervisions took place every six months. Staff records showed that any actions from the previous supervision were followed up. For example, when a member of staff had requested a change in their work pattern it was recorded when the action was completed.

Health care services were made available to people when needed. Staff made a referral to local health and social services when people's health care needs changed. For example, staff had contacted the emergency services when a person became suddenly unwell. They initially made contact with the office based staff who offered the member of staff advice. We found that when people's needs changed staff took appropriate action to obtain health care advice when required.

Meals were provided by staff which met people's needs and preferences. People's care records showed where people needed support with shopping for food and to prepare meals. People we spoke with told us that staff prepared meals of their choice. One person told us that staff made them breakfast another told us that staff prepared their meals in the way they wanted. People had meals they enjoyed and told us staff provided this for them.

Requires Improvement

Is the service caring?

Our findings

At the last inspection in July 2016 we found that people were not always provided with support that was caring. People we spoke with told us they staff did not always provide support for the expected length of time and support was not always provided in line with their preferences. People also told us that they did not always receive care from staff who they knew and were familiar with their needs.

People provided mixed views on whether care staff were caring. One person said "The staff are very kind." Others said "They are very caring. Very friendly. Very polite" and "They are very good." A relative said "Yes, they are very kind to my relative." Another person said "I am very happy. If I ask them to do something, they always do it." One relative said "I have always witnessed [care worker] being kind and caring." However other people we spoke with said some staff were not caring. People told us that this was most noticeable when they had a change in care worker. People said that the lack of continuity in care workers undermined the ability of care workers to understand their care needs, build up trust and a rapport with them. One relative told us that because her family member did not know the care worker well, they would refuse help with personal care from them. A person using the service said "It is dreadful. I don't know who is coming through the door." Another person said "Every time a new care worker. I see four different care workers each day and it's not even the same four the next day." We found that those people who received continuity of care from the same care workers were more confident about their care than those who experienced frequent changes in care worker.

People we spoke with had mixed views about how staff protected their dignity and ensured their care and support was carried out in privacy. One person said, "She seems to understand quite all right." Another person said "Yes, they understand. I have no complaints. They are very good" and one commented "they do a splendid job." A relative said "They have done a good job so far." However, another relative said "They are very young and inexperienced. The language abilities of some of the care workers are not good". One relative said "The service is not good. They do not bathe my relative properly."

Staff supported people so they could remain as independent as possible. People attended activities of their choosing. Their care records detailed where people required specialist support to access their local community. When required staff accompanied people to go shopping, attend appointments or to attend the local daycentre of their choice. People maintained their independence while doing things they enjoyed with support if needed.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection on July 2016 we asked the provider to take action to make improvements, and this action has not been completed. People's care plans were not always reviewed and updated in line with the provider's policies and procedures. We found that people did not always feel that their complaints and concerns were managed well. People using the service told us that outside of the office hours they had difficulty contacting staff in the office.

People had an assessment before receiving care and support. Prior to the assessment, the local authority provided an initial assessment. The field supervisor visited the person to complete an assessment following a referral from the local authority. Following this a care plan was developed. However, we found that people did not have assessments that were person centred or reflected changes in care and support needs. People's care plans were task focussed, for example, where people needed help with washing and dressing this was recorded but they did not include the person's preferences about how this was completed. We found where a care plan review had taken place and people's care needs had changed, this was not always included. We found on one occasion a person required support with their meal preparation however, there was no information recorded on food preferences or how food should be prepared. Care plan reviews were completed on a regular basis with the contribution of people using the service or their relatives where appropriate. Decisions about care planning including people's likes and dislikes were recorded. However, we found that people's care plans did not provide details of people's views about how they wanted to be cared for. We saw that six people's care records had not been updated. This meant that people did not have the most accurate information about their care needs available. This increased the risk that the care and support provided could be inappropriate to their needs. The above relates to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did tell us that they were involved in an assessment of their needs. They told us that staff had visited them to identify their needs. People told us that staff were respectful towards them and supported their wishes. One person said, "They do listen. If I ask them to do something, they always do it."

Some aspects of the service were responsive to people's needs. The registered provider had identified that some people living in the local community required additional support. Some people received a care service however there was also a need for a befriending service to combat social isolation. Care workers identified people who they thought would benefit from engagement with a volunteer. The volunteer co-ordinator told us. "We see and visit a lot of people in the community who are lonely and need a befriender." We saw care records that demonstrated that the input of the volunteer service positively affected their health and well-being. For example, each person using the service was valued and made to feel special. People had their birthday celebrated by staff, staff fund raised to provide basic equipment such as towels and bedding for people who needed that additional support. People using the service benefitted from developing relationships with staff while building friendships.

People had access to a complaints process. People understood that they could make a complaint about the quality of care they received if they needed to. People using the service and staff were aware of the

provider's complaints policy and staff were able to support people to use this if needed. The service users' handbook had information in it that described how people could make a complaint or raise a concern with the service. One person told us "I have got the office number." People knew how to make a complaint and we saw copies of the complaints the service had received in the past year. We saw that the registered manager managed complaints in accordance with the provider's policy and procedures. Staff recorded the details of the investigation and informed the complainant of the outcome at the conclusion of the investigation. This demonstrated that staff acted on people's complaints and took action to resolve these issues.

Inadequate

Is the service well-led?

Our findings

At the last inspection in July 2016 we asked the provider to take action to make improvements, and this action has not been completed. People did not have the opportunity to provide feedback to the registered provider because they were not asked for their opinion. We also found that the registered provider's quality assurance systems and processes did not effectively assess and monitor the service. We found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found sufficient action had not been taken to meet this regulation.

People we spoke with had mixed views about the management of the service. One person said, "They are dreadful. Haven't got a clue." One relative said "The administration is not brilliant. In fact, it is a shambles." Another relative said they had to tell the registered provider several times over a three week period that they should not send a care worker to their family member at lunchtime because they were now attending a day centre. This relative added that they thought the internal communication within the company was "poor". Another relative said, "It was better organised when the nuns were involved." However, one person also stated "I think they are well organised. They do work quite all right for me. No complaints." Another person who was asked if the provider was well organised, said "No complaints." A relative said "Looks as though it is all done properly."

Staff shared their comments about the management of the service. These views were mixed. One member of staff told us "There's a problem with management. I don't think they are fit for the job. They don't care about the patients or the care workers. They just do the rotas and send people from North to South, South to West. We have to run and rush all the time. They don't consider the distance. They don't know the needs of our patients. There is no continuity of care." Another care worker commented that "Most of the time you can get through to the office, or they get back to me." And "We always report problems to the office. The office is flexible. It's a flexible job."

We found that the service had carried out quality assurance audits of the service. Staff carried out spot checks on care staff on a regular basis to ensure that they were providing appropriate care and support to people. This allowed office based staff to assess the practice of care staff and to provide support and guidance to care workers if needed to improve their practice. However, we found that the systems to manage, effectively review, monitor and audit the service and quality of care was not effective.

There was a risk that people did not receive visits because the service did not have clear records which showed how many people missed and late visits affected. We looked at the system used to arrange the staff rota. The registered manager told us that there were some concerns about the quality and effectiveness of the system. They added that they had to do a manual check of all staff rotas for errors. One member of staff told us their daily work rota contained errors in them and they had to check the details of the rota with the office based staff regularly. This increased the risk of people not receiving the care required and meant that the registered manager could not monitor patterns and trends regarding missed visits and late visits and to mitigate the risk of recurrence.

The quality of people's care records was not regularly reviewed to ensure they were accurate and of a good standard. There were no processes for staff to complete quality audits of people's care records. We found that people's care records contained errors or had not been updated with changes in care and relevant information to enable staff to safely care for people.

The registered manager and staff carried out an audit of medicines. However, on review of the medicine audit system we found that people did not always have a MAR chart in place. The system of reviewing people's medicines was unsafe because the names of the medicines were not always recorded on people records. We also found that people were not acting in accordance with the registered provider policy on medicine management. We asked for a copy of the medicine audits completed by staff. We were not provided with this information because staff did not have arrangements in place to report on the audit of medicines. Therefore any errors in medicine administration would not be detected and managed to mitigate risks.

We found records relating to people using the service were incorrect. Before the inspection we requested an up to date list of the names and contact details of people using the service. We found that the information sent to us was not accurate. We found 21 people on the list provided did not have a contact telephone number recorded. Staff could not be confident that people could be contacted if required, because their contact information was missing. Therefore, people's contact details were not accurate.

The service obtained feedback from people using the service. Following the last inspection staff sent written questionnaires to people. This allowed people the opportunity to comment about the service. The feedback was mixed. While some people gave positive feedback other people raised their concerns about the consistency of care workers and their time keeping. We asked the registered manager how they shared this feedback with staff. They told us the feedback was discussed at team meetings. However, we did not see any records that demonstrated what actions the registered manager was going to take to resolve the concerns people raised about the service.
The above issues were a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014.

The registered manager informed CQC of notifiable incidents that occurred at the service. The registered manager informed CQC of safeguarding allegations that the service is required by law to tell us about. We asked the registered manager for records of safeguarding allegations and we were provided with this information.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA Regulations 2014 Person centred care. The provider did not ensure that care and treatment was appropriate, met people's needs and reflected their preferences. Regulation 9 (1) (a), (b), (c)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HSCA Regulations 2014 Need for consent. The registered person had not always acted in accordance with the Mental Capacity Act 2005 (Regulation 11(1)(3)