Clece Care Services Limited

Clece Care Services Ltd (Gateshead)

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 19, 21 and 22 January 2016 and was announced. This was the first inspection of the service since registration. The service had been operating since August 2015 whilst under the registration of another of the provider's locations until it was registered as a separate location in December 2015.

Clece Care Services Ltd Gateshead provides personal care and support to people in their own homes in the Gateshead area. At the time of our inspection services were provided to approximately 180 people, mainly older people including people with dementia related conditions.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found the service did not have enough staff and there was insufficient capacity to consistently deliver people's care. Many staff had left employment and there were pressures on care workers to work extra hours. Management of the staff rosters was not effective and there was no proper system in place for checking visits and whether care workers had carried out their rostered calls.

There had been a significant number of times when visits to people were missed and their care was not given. Many of the staff were not trained in protecting people from abuse and robust procedures were not followed in response to safeguarding concerns.

Risks to people's safety and welfare had not been clearly identified and acted on. Care records gave staff limited or no guidance about the ways to meet people's needs and minimise risks. Appropriate arrangements had not been made to ensure that people received their medicines safely.

New staff were checked and vetted to ensure they were suitable to be employed. However, there was no documented evidence that new care workers had received training to prepare them for their roles. There was inadequate staff training provided and no structured systems for supervising staff and checking on their performance.

Staff reported concerns about people's health and welfare to ensure they received input from health care professionals. Staff prepared meals and drinks for people who required such support to meet their nutrition and hydration needs.

No systems had been developed to enable people to give their formal consent to their care and treatment. The management lacked understanding of the implications of mental capacity law and the processes for upholding people's rights.

The people and relatives we consulted had good relationships with their regular care workers. They told us staff were caring and most treated people with respect, though we found there had been some issues with lack of confidentiality.

With the exception of initial assessments of needs, the views of people and their families about their care had not been sought. None of the people using the service had care plans to demonstrate how their care must be provided and people's care had not been reviewed.

Where people needed support aimed at preventing social isolation and to access the community this was provided. The service had a complaints procedure and action was taken to respond to complaints.

Poor governance arrangements were in place. Staff felt unsupported and morale was low. No systems had been implemented to assess and monitor the standards of the service and the quality of the care that people received.

Enforcement action is being taken as a result of our inspection findings outside of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were insufficient numbers of staff to safely support people and meet their needs.

Appropriate steps had not been taken to safeguard people using the service from harm and abuse, and to respond to allegations of neglect.

Risks to people's personal safety were not adequately assessed and managed.

The arrangements for supporting people with their prescribed medicines were not safe.

Is the service effective?

Inadequate

The service was not effective.

Staff were not trained and supported to carry out their roles to ensure they could care for people effectively.

The implications of mental capacity law were not understood and implemented.

Staff supported people in meeting their dietary needs and checked on their health and welfare.

Is the service caring?

Requires Improvement

The service was not always caring.

People and their families were not supported to express their views and be involved in decisions about planning their care.

There had been issues of lack of confidentiality in relation to people's personal information.

People told us their regular care workers were kind and caring and they had formed good relationships.

Is the service responsive?

Inadequate

The service was not responsive.

People using the service did not have care plans to demonstrate how staff must meet their needs.

People received care aimed at reducing social isolation.

A complaints procedure was in place that people understood and had used.

Is the service well-led?

Inadequate

The service was not well-led.

The management had not ensured that adequate standards were maintained at the service.

The quality of the service and risks to people's health, safety and welfare had not been assessed and monitored.

The provider had failed to notify the Care Quality Commission of circumstances affecting the service and people using the service.

Clece Care Services Ltd (Gateshead)

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

The inspection was announced and took place on 19, 21, and 22 January 2016. We gave 48 hours' notice that we would be coming as we needed to be sure that someone would be in at the office. The inspection was carried out by two adult social care inspectors and an expert-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 reviewed the information we held about the service. We had not received any notifications from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We had received concerns about the service which led us to carry out an earlier than planned inspection. We contacted the local authority and were informed they had concerns about the service regarding staffing, missed visits, arrival times, duration of visits, the quality of care plans and risk assessments, and continuity of care.

We gathered information during the inspection using different methods. We spoke with 15 people who used the service, eight relatives and four care workers by telephone to get their feedback. During our visit to the office we talked with the provider's compliance and quality manager, the registered manager, an acting manager, two care co-ordinators and other office-based staff. We looked at 10 people's care records, medicine records, staff recruitment and training records, and reviewed other records related to the management of the service.

Inadequate

Is the service safe?

Our findings

At the time of our inspection there were approximately 180 people using the service who needed around 1600 hours of service provision each week. We found there were significant shortfalls in the service's staffing resources and capacity to meet people's contracted hours of service.

The service had been operating since August 2015 after being awarded a contract by the local authority to provide domiciliary care in the Gateshead area. A care co-ordinator told us that since that time 51 staff had left the service. There were currently 62 care workers employed. This was insufficient as there was an estimated weekly shortfall of service provision of 124 hours. This did not include any reduction in care workers availability due to annual leave and sickness absence.

The registered manager told us that due to the current staff shortages the service was struggling to provide cover for visits to people, particularly in the evenings and at weekends. Staff were being asked to work their days off and planned leave was having to be reviewed. An electronic rostering system was used and we were shown that visits for eight people later in the week had not yet been allocated to care workers. Some of these were to find a second care worker where people required two staff to deliver their care. A co-ordinator told us they had on occasions provided cover for visits themselves. An on-call system was operated outside of office hours by the management and senior staff for staff to get support and advice. However one care worker told us, "There's been loads of times when I've had no response, affecting people's care."

There was no electronic call system in use to enable office based staff to monitor when care workers arrived at and left people's homes. This meant they were not being alerted in a timely way when care workers did not turn up and had no means to check the timing and duration of visits. When visits were missed, the registered manager and staff co-ordinating the service were reliant on being contacted by people and their representatives, or by the care workers who next visited the person.

The registered manager and a co-ordinator told us staff were provided with their weekly rosters in advance of visits to people. Care workers did not confirm this and told us they were often given rosters at short notice, with details of allocated visits only for the next two to four days. One care worker told us they had just received their roster on that day and this had meant they had been late to every person they visited. Another care worker commented, "I haven't got my rota for tomorrow."

Care workers reported they were routinely expected to work extra hours in order to cover visits. Some told us these extra hours were put onto their rosters without them being asked if they were able to accommodate them. The care workers we talked with were aware of the staffing shortages. They felt there was low morale in the staff team and some said they were considering leaving their employment. Their comments included, "There's too much pressure. They won't take no for an answer. Staff are getting messed about and leave"; "The office staff don't listen"; "Some staff pick and choose what hours they'll work"; and, "I'm miserable in my job and looking for other work. They're crucifying me, it's exhausting."

Information was provided to us the week following the inspection that gave further cause for concern about

the staffing capacity. Commissioners of the service reported the weekly shortfall had risen to 200 hours and the provider's action plan to the local authority stated there were now 54 care workers employed. The local authority confirmed to us that because of the staffing concerns they had transferred the care of some of the people using the service to their own care provision. We concluded that the provider had failed to deploy sufficient numbers of staff to meet people's needs.

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

Before the inspection we had received concerns, including some from staff, about the impact of staffing shortages on people using the service. We contacted the local safeguarding authority and were informed there had been a substantial number of safeguarding allegations about the service. The majority of these related to people being neglected as their care and support visits had been missed. Alerts had also been raised which were subject to investigation by the police. We were informed the management of the service had not always given timely responses to the safeguarding authority of their investigations into the missed visits. The safeguarding authority confirmed that since August 2015 there had been 70 safeguarding concerns, 13 of which had been raised since the service's registration in December 2015.

The registered manager and acting manager told us they were submitting reports of all missed visits to the commissioners of the service and the safeguarding authority at Gateshead Council. Each of these was being logged as a safeguarding issue. However, records of safeguarding incidents held at the service did not fully correspond to the information provided by the safeguarding authority. The full extent of missed visits since registration could not be provided by the registered manager as it was not available, meaning there was inaccurate written information held about safeguarding issues at the service.

We found the reports of missed visits were often incomplete and lacked details of any meaningful action taken in response to keep people safe. For instance, there was no evidence to suggest the service had arranged replacement visits to people where this would have been possible. The compliance and quality manager confirmed to us that the company's policy and procedure for missed visits had not been followed.

Records showed that 25 of the 65 staff employed had not completed training in safeguarding adults from abuse. This placed people at risk of harm as it meant that not all staff caring for them had the knowledge to understand how to prevent and report abuse.

The compliance and quality manager informed us that a new whistleblowing (exposing poor practice) leaflet had been produced and was being given to staff in the near future. They also showed us that a 'duty of candour' policy had been introduced and was being rolled out to the managers of the provider's services to disseminate to staff. This duty requires providers to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong.

The registered manager said only one person using the service was supported with their personal finances. The records kept of transactions were suitably recorded and receipts were kept of purchases. The senior supervisor had carried out one check to date to ensure the person's money was being handled safely. We queried, given the numbers of people using the service, whether it was likely staff might be handling money for more people, for example, if they were asked to do some shopping. The registered manager was not aware of this though acknowledged it was possible. They said they would arrange to have financial transaction sheets put into each person's care file in their home.

The high volume of safeguarding issues demonstrated that people had been neglected and placed at risk of harm due to not receiving their care service. Concerns about staff turnover and resources, ineffective roster management and the lack of a proper system to monitor visits meant people continued to be at risk of neglect. We concluded that the provider had failed to protect people using the service from abuse and had not established and operated effective systems and processes to prevent and respond to abuse.

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

Inadequate care documentation was available to guide staff about safely meeting people's care needs and reducing risks during care provision. In many of the records we examined the assessments of care needs and risks had not been fully completed. It was evident that many people were physically frail and vulnerable, but important areas of their care and control measures for risks had been omitted from, or were not clearly specified in their care records.

No care plans were in place. A section of the care needs assessment was used to record the services and personal care required. However, the information here was extremely limited, giving little or no guidance to staff of how they were to provide care and manage risks to people's safety and welfare. For example, one person's assessment stated in their medical history, that they were unable to walk, were at risk of falling and had previously sustained injuries which affected their dexterity. The person had four visits each day and needed two care workers to provide their care. Their home environment and moving and handling needs had not been assessed. No possible risks had been identified in relation to the person having pressure damage and diabetes. The only information recorded for staff about their care provision was: '(Name) in bed when carers arrive, a full body wash every morning'; 'Pads and medication is in the living room'; 'Once ready and dressed assist (name) into living room into chair by the window'; and, 'Evening call. Assist into bed'.

We found numerous other instances where there were no strategies for managing risks associated with people's health conditions, mobility, falls, moving and handling and administering medicines. We concluded that the provider had failed to assess the risks to the health and safety of people using the service and had not done all that was reasonably practicable to mitigate such risks.

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

People using the service told us they were happy with the way their care workers supported them to take their medicines. However, we found that the arrangements for managing people's medicines were unsafe. A record of people's prescribed medicines was not always made or kept up to date. Where lists of medicines had been documented, they did not always correspond with those detailed on Medicine Administration Records (MARs) and topical medicines and inhalers were often omitted from the MARs. This meant it was not clear what medicines should have been, or were being, administered to the person.

Some people's medicines risk assessments had not been fully completed and did not specify the level of support the person required. Other assessments were inaccurate, stating a lesser level of support such as prompting the person to take their medicines was needed, when in practice we established that staff were administering people's medicines.

The management was unable to provide accurate details of the numbers of staff who had been trained in the safe handling of medicines. Where staff claimed to have received this training from previous employers, this had not been corroborated. The compliance and quality manager informed us there was a system for

assessing the competency of staff in handling medicines. This system had not been implemented at the service and there was no evidence that any competency assessments had been carried out.

Reports of those occasions when people's visits had been missed showed that the purpose of the visits often included staff giving people assistance with their medicines. This was evident in seven of the nine available reports of missed visits in the time since the service had been registered. Only two of the seven reports indicated that staff had administered medicines later the same day. Another two reports stated it had been necessary for the people to be assisted with their medicines by a friend and a family member. There was no other evidence that follow up action had been taken to ensure that, where practicable, arrangements had been made for staff to visit people and administer their medicines at the earliest possible opportunity. The compliance and quality manager informed us that the late and missed visits policy and procedure incorporated action to be taken in the event of medicines being missed. They confirmed this policy and procedure had not been followed.

We saw that some people's MARs had been returned to the office, though not with any consistent frequency. These records had been filed away without any checks or auditing taking place to identify any discrepancies. We examined the MARs and found they contained numerous recording deficits, including substantial numbers of gaps where staff had not signed to confirm they had administered medicines to people. We concluded that the provider had failed to mitigate the risks associated with the unsafe management of medicines.

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

The registered manager told us there was on-going recruitment and six new care workers were in the process of being appointed. We checked recruitment records for some of the last staff employed and found that all necessary checks had been carried out. Application forms were completed and proof of identity was obtained. Two references were sought, including one from the last employer and Disclosure and Barring Service checks were carried out. Interviews had been conducted. We found that new staff had been properly checked and vetted to ensure they were suitable to be employed.

Prior to this inspection we had received a concern alleging a care worker had been dismissed and then re-employed. We looked into the allegation during the inspection. We found no evidence to support the allegation and the registered manager told us this would not be allowed.

People using the service and their relatives told us they felt safe with their care workers. Their comments included, "She (care worker) is very trustworthy"; "I have no worries at all when she is in the house. She gets the key from the box (key safe) and lets herself in but she always shouts so that I know it's her"; "I know they are good because (my relative) speaks highly of them and they would soon tell me if anything was wrong"; and, "I feel very safe with her (care worker)."

Inadequate

Is the service effective?

Our findings

We found that staff were inadequately trained and supervised. Records for two of the latest care workers employed contained no evidence of induction training. The registered manager and acting manager were not aware of the extent of training provided to staff and had difficulty locating details of training. On the second day of our inspection we were given an overview completed by 58 staff. This overview gave brief details of three topics of training, with no dates of when the training had been completed. It showed that eight staff had not completed medication training; nine had not completed moving and handling training; and 46 had not completed first aid training. The overview included staff who had transferred to the service under TUPE (Transfer of Undertakings Protection of Employment) arrangements and did not specify whether the training completed had been with their current or previous employer. It was not possible for us to establish further the extent of training provided by the service and the management were unable to give clarification.

The overview of training also indicated that 41 staff had not completed e-learning training, the topics of which were not stated. We were given information by the acting manager that verified the e-learning training consisted of modules for complaints; COSHH (Control of Substances Hazardous to Health); fire safety; epilepsy; food safety; health and safety; infection control; data protection; lone working; RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations); and safeguarding.

We asked about any further training undertaken or planned for the staff team. The acting manager told us they were looking into providing staff with training from the local authority on safeguarding and the Mental Capacity Act 2005. There was no evidence offered that this training had been arranged. We were also informed that the service had places for 20 staff to undertake Diplomas in Health and Social Care qualifications. There was no information about which of the staff would enrol and copies of emails from within the provider's company requesting this information had not been responded to.

We checked the arrangements for providing staff with individual supervision. No schedule or plan for supervision could be located by the registered manager during the inspection. We found supervision records were available for only five of the 65 staff. A further six supervision records, which had been misfiled, were located at the end of the inspection visit.

The care workers we spoke with told us they had received little or no training since starting work at the service. Some reported having had previous care experience and training with their former employers. Their comments included, "We're not getting the support. The office staff don't listen"; "I've only had one supervision and been to one staff meeting"; "I had induction but no shadowing"; "I haven't had any training or supervision since I started"; and, "All I've done is some e-learning. I was well trained at (name of previous care employer)." We concluded that the provider had failed to provide staff with 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 2008 (Regulated Activities) Regulations 2014.

We saw that care needs assessments included some information about people's perceptions of their needs and of their current mental health and level of cognition. The assessment also asked whether the person was able to give their informed consent to the care and treatment which would be provided, and if not, the name and relationship of the person nominated as their representative. However, as people had no care plans setting out their care and treatment, there was nothing tangible for them to give their consent to.

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.

Staff were not trained in the implications of the MCA. The registered manager and acting manager told us they had undertaken relevant training. However, both managers lacked understanding about their responsibilities and did not know if anyone had, or needed to have, their mental capacity assessed, or if any 'best interest' decisions were in place. They were also not aware of whether any person had a legally appointed representative, such as a power of attorney, who could make decisions on their behalf about their care. We concluded that the service was not working within the principles of the MCA to ensure people's rights were being properly protected.

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

Details of people's medical history, health and any aids and equipment they used were obtained. There was evidence in the on-call log that staff had reported concerns about people's health and well-being and, where necessary, contacted health professionals such as doctors and district nurses. A relative told us, "If they're at all worried that my relative isn't too well they always tell me that I need to call the doctor."

People's dietary requirements and food and drink preferences formed part of their care needs assessment. Some people who used the service were supported by staff with meals, snacks and drinks. A relative told us, "We have a message book system because my relative has terrible memory loss so we can write messages for the carer and she leaves messages for us. She always makes sure there is a loaf of bread in the freezer because my relative has a habit of leaving bread on the table and it goes dry and sometimes mouldy. Because we know there is another loaf in the freezer it's not a problem. The carer is very thoughtful like that."

People and their relatives told us they felt their care workers knew what they were doing and were happy with their regular workers. Their comments included, "They go over and above what they need to do"; "She (care worker) is really good and reliable. I would miss her terribly if she didn't come"; "They are very good. I have a regular person which I like. She comes at the same time every morning. She's never more than five or ten minutes late and she gets my breakfast and makes my bed for me"; and, "They do everything for me. I can't do anything for myself. If it wasn't for them I would be in a home and I'd hate that."

Requires Improvement

Is the service caring?

Our findings

We found that people and their representatives had been afforded limited opportunities to express their views and be involved in decisions about their care and support. One person told us, "I only see the carer. I think somebody came at the beginning when they took over, but I don't remember anything about a care plan and nobody has been since. I just talk to the carer." There was some evidence that people and their families had been involved in the initial assessments of care needs. However, no care plans had been developed with them to ensure their needs and preferences would be met. The management had not sought people's views about their care or the service provided to date and no reviews of care had been conducted. This meant the provider had not done everything reasonably practicable to ensure that people were provided with person centred care.

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

People and their relatives told us their care workers were kind and compassionate and many spoke of the good relationships they had with their regular workers. One person commented, "She goes the extra mile. Nothing is too much trouble and I couldn't do without her."

People also spoke positively about their care workers approach. One person told us, "I wasn't very happy about having people do some things for me like helping me in and out of the bath but they are so good and really respectful so I've got used to it now." Another person said, "My carer is ever so thoughtful. She always takes the time to have a chat with me while she's filling the book in. That's a big part of caring as far as I'm concerned, taking time to talk to me."

A relative told us, "I've just cancelled the service. We only had them to help with my relative because I'd had major surgery and needed the help, but I'm much better now and can cope again. I shall miss her (the carer) to be honest. She was brilliant with my relative and very discreet. He was very unsure about having them at first but she really put him at ease. I wouldn't hesitate to have them again if I needed help." Other relatives' comments included, "The carers are lovely people. They honestly are just brilliant"; "They are very kind and they always ask how I am as well which is nice"; and, "He (the carer) will do anything and everything and is always cheerful. My relative didn't want a lady to see to him and we have a man every morning so he is happy with that."

People and their relatives were happy with the care and support provided. One person said, "What I do like is the way they always ask if I want something doing. They don't tell me what to do, they always ask. For example, I normally get up early but if I'm not feeling too good in the morning they take more time and ask if I want to stay in bed a bit." A relative told us, "I feel included with (my relative). You can soon feel helpless if you can't look after somebody but they make me feel just as important."

However, one person's relative questioned if staff were appropriately trained with regard to respecting people's dignity and confidentiality. They described recent circumstances when care workers had

inappropriately discussed a sensitive issue concerning their family member with other relatives. The relative told us they had considered taking up their concerns and commented, "But it is a minority of the carers. I don't want it to get so that carers don't trust me or think they can't talk to me." We noted that another concern about lack of confidentiality had recently been logged as a complaint with the service.

We saw that care workers received an employee handbook that set out the provider's expectations about confidentiality, privacy, dignity, independence and anti-discrimination. It also stated the rules workers must observe when visiting people. These included always asking people how they wished to be addressed; knocking or ringing the doorbell and speaking out before entering a person's home; and respecting people's privacy and wishes.

The registered manager told us that none of the people using the service had advocates to act on their behalf. They had information about advocacy services and knew how to refer people if this was required. The registered manager said people had been given a guide that explained what they could expect from using the service. They told us there had been occasions when people were introduced to their workers before they started working with them, though no evidence of this was documented. The registered manager said they aimed to accommodate people's preferences for male or female care workers, more mature care workers or workers with particular skills and interests. A care co-ordinator told us they always tried to keep people with the care workers who were known to them from when they had other care services. Care workers spoke fondly of the people using the service and told us they knew those people they visited regularly well.

Inadequate

Is the service responsive?

Our findings

Care workers told us they were currently covering visits to people they did not usually visit. Some were concerned about the impact on the continuity of care that people were receiving. They told us, "I do the job to the best of my ability but some people don't get the time they need"; "We're not getting enough time with people. It's impossible with the travelling"; and, "I get asked to squeeze people in for visits. People complain to me about the number of carers they get."

Whilst most people we spoke with said they were satisfied with the support they received, we found that their care had not been appropriately planned and reviewed. A range of assessments were available to identify people's needs and risks associated with their care provision. However, the assessments were often only partly completed and some gave inaccurate information about the care that people received in practice. There was a complete absence of care plans and the registered manager confirmed to us that none of the people using the service had care plans in place. They could give no reason or explanation for this, other than that a section of the care needs assessment was used to record people's care. However the information we saw recorded here did not constitute a care plan and mostly took the form of a few brief and unspecific comments. This meant there was no reliable written guidance for care workers to follow in order to deliver people's care. The alternative of staff reading through the assessments was not judged to be practicable and in most instances the assessments did not accurately describe the care that needed to be provided. The compliance and quality manager told us care plan documentation was available to the registered manager and said this should have been completed for all of the people using the service following assessments being carried out.

The compliance and quality manager told us it was the provider's policy that everyone using the service should have a review of their care within three months of their service starting, and thereafter every six months. Many people had received services since August/September 2015 but there was no evidence that any reviews had been carried out or were planned. This meant no checks had been made to seek people's views and evaluate their care to see if it was appropriate or if any changes were needed. We concluded that the provider had failed to maintain accurate and complete records of people's care, placing people at risk of unsafe or inappropriate care.

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

People using the service told us it was important to them to have the same care workers and said they nearly always got the same workers. One person said, "I generally get the same carer unless she is on holiday and she is marvellous." Another person said, "They are very good and always on time. I get half hour visits which is enough and she does stay the full time. I have my own routines which she understands."

Care needs assessments gathered some information about the person's lifestyle and history. A minority of people using the service received support aimed at preventing social isolation. They had dedicated care workers for one-to-one support time for accessing the community, shopping and household support.

We saw detailed information was provided to people in the guide to the service about how to make a complaint if they were unhappy. None of the people and relatives we spoke with had experienced any problems which they felt they had needed to report to the service as a complaint. A relative told us, "I would definitely know what to do if we had any concerns but we really haven't."

We examined the complaints log and found that 12 complaints had been made, dating from October 2015. Most related to people's visits being late and three complaints were about the same person's care and support. The majority of complaints had been followed up and action taken in response, though the latest was pending investigation due to a staff member's absence.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager. They told us that soon after being registered they had been promoted to another role within the company as operations manager, with responsibility for the service and another of the provider's registered locations. An acting manager had been employed who had worked at the service since December 2015 and this person informed us they would be applying for registration. The acting manager was being mentored by the registered manager but no formal induction training had taken place to prepare them for their management role.

We found that the registered manager and acting manager were not aware of, or had not followed, many of the provider's policies, procedures and systems. These included the policy and procedure for late and missed visits; risk management; care planning and reviews of care for people using the service; weekly branch activity reports; scheduling of staff supervisions; maintaining records of staff training; and systems for monitoring the quality of the service.

The standards and quality of the service had not been assessed or monitored to date. The provider's compliance and quality manager told us they had just commenced an audit of the service that had coincided with the time of the inspection. They said managers were meant to send weekly reports to their line manager to appraise them of specific events and the running of the service. The registered manager confirmed they were unaware of the existence of these reports or the weekly reporting system.

We had found that there was limited or no written information to guide staff on meeting people's needs and managing risks. This was endemic throughout the care records we examined and demonstrated a lack of management understanding and action about how to mitigate risks to people's health, safety and welfare.

There was no structured system for returning people's completed care records from their homes to the office. Where records had been returned, such as completed daily diary records of visits and Medicine Administration Records, they were filed away without any checks. The registered manager confirmed there was no process for auditing the records to validate whether people had received safe and appropriate care.

We checked if any other methods of quality assurance had been implemented. There was recorded evidence that two of the 180 people using the service had received a 'quality assurance visit' but no evidence of care reviews being carried out. One of the 62 care workers had had a spot check of their performance. There were no plans available for further quality assurance visits, reviews and spot checks to be conducted. Surveys to check people's satisfaction with the service had not yet been sent out.

Shortfalls in the staffing capacity had increased over the time the service had been operating. A care co-ordinator informed us that a total of 51 staff had left the service, 22 of whom had left without giving notice. The registered manager confirmed no analysis had been carried out to monitor the reasons why so many staff had left employment, nor had any attempt been made to mitigate the risks of this reoccurring.

The registered manager and acting manager believed the high numbers of missed visits to people were mainly caused through rostering problems. These problems had not been resolved, according to care workers we spoke with. Care workers reported they were routinely given their rosters of visits with little advance notice. An electronic call system to monitor when the care workers arrived and left people's homes had not yet been implemented. We were told this was going to be trialled in the near future. The shortfalls in the staffing capacity, continuing problems with rosters, and a lack of monitoring of care workers' visits meant that the risks of further missed and delayed visits were not being mitigated.

None of the people using the service we spoke with had formed an opinion about the management or leadership of the service. One person said, "They only took over last year and up to now everything is going well so I can't say any more than that."

Three of the four care workers we talked with were unhappy with their employment arrangements and did not have confidence in the management. They told us, "It's not a very good company. I used to love working for them but now the staff are tired, not valued and there's no thanks."; "I'm thinking about leaving"; and, "They're unprofessional. There's too much pressure and I've applied for another job."

We concluded that there were ineffective governance arrangements at the service. The provider had failed to establish and operate systems and processes to assess, monitor and improve the quality and safety of the service; and to assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service.

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

The Care Quality Commission (CQC) had not received any notifications of significant events from the service in the time since the service was registered, or prior to this when the personal care was being managed from another of the provider's services. The provider had failed to ensure that CQC was notified about insufficient numbers of staff being employed to provide personal care to people using the service; and of any abuse or allegations of abuse in relation to people using the service.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 did not take formal enforcement action at this stage. 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 The registered person had not ensured that care and treatment was designed with a view to achieving service users' preferences and ensuring their needs were met; and had not involved relevant persons in decisions relating to the way in which the regulated activity is carried on in so far as it related to the service user's care or treatment.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person had not ensured that care and treatment of service users was only provided with the consent of the relevant person or acted in accordance with the Mental Capacity Act 2005 where service users lacked capacity to give consent.