Fosse Healthcare Limited

Fosse Healthcare - Leicester

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out the inspection on 8 and 15 December 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available.

The service is a domiciliary care agency that provides personal care and support to people in their own homes. At the time of our inspection 119 people used the service.
The month prior to our inspection Fosse Healthcare had secured a large contract to provide care packages to people who had previously received their care from other providers. This meant that they were providing over double the care calls in the second week of November than they had the previous week. As part of this process Fosse Healthcare had transferred a number of staff from other providers to be employed by them. We had received feedback from people using the service, their relatives and the local authority that there were concerns about the quality of the care provided and significant disruption to people's care packages. While the provider had clearly made some progress, at the time of the inspection a number of concerns remained.

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.

People did not feel safe because they could not be sure that staff would arrive to provide their care. People could not be sure that they would receive their medicines as required. Staff were not given clear guidance and support in order to ensure that people were supported to take their medicines.

Staff had received training to keep people safe and understood how to raise concerns. Where issues relating to people's safety had been identified they had not always been recognised and reported as safeguarding concerns.

Safe recruitment checks had taken place prior to staff employment. Staff understood their role in keeping people safe. Assessments regarding risks to people were not always completed, as a result people were not protected from the risk of avoidable harm.

Staff had received training and supervision to meet the needs of the people who used the service. Staff told us that they felt supported.

People were not supported in line with the requirements of the Mental Capacity Act 2005 (MCA)

People were supported to maintain their health. Staff provided people with food and drink to meet their nutritional and hydration needs.

People's independence was promoted and people were encouraged to make choices. Staff treated people with kindness and compassion. Dignity and respect for people was promoted.

People's needs for care had not always been assessed. Staff were not provided with a sufficiently clear understanding of how to support people who used the service. People did not always receive their care at the times that they needed or preferred.

People did not feel that they were listened to or that they could make contact with the service in order to request changes. Complaints were not managed in line with the provider's complaints procedure. Systems where not effective to review the care that people received and to check that these were in line with their assessed needs. Checks on the quality of the service that people received were in place but these were not robust.

The provider did not have an effective system for monitoring call times and ensuring that people received the care that they needed to remain safe. Audits had not been effective in identifying concerns and it was not clear what action had been taken to prevent re-occurrence.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe

People did not feel safe. They could not be sure that they would receive their care calls when they needed them.

Risks associated with people's care needs had not always been assessed in order to protect them from avoidable harm.

Safe recruitment practices were followed. Staff understood how to report concerns about people's safety.

People could not be assured that they received their medicines as prescribed by their doctor.

Is the service effective?

Requires Improvement

The service was not consistently effective

People were not supported in line with the requirements of the Mental Capacity Act 2005 (MCA)

Staff had received training and support to meet the needs of the people who used the service.

People were supported to maintain their health, their nutritional and hydration needs were met.

Is the service caring?

Good

The service was caring

People were usually supported by people that they knew.

People were provided with information about the service and the care that they should expect to receive.

Dignity and respect for people was promoted. People's independence was promoted and people were encouraged to make choices and felt involved.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

People's care needs had not always been assessed. Care plans did not provide the level of detail that staff required to ensure that they met people's needs.

People did not receive their care at the times that they wanted or expected it.

Complaints had not been addressed in line with the provider's policy.

Is the service well-led?

Requires Improvement

The service was not consistently well led

People did not feel listened to.

There was not an effective system for monitoring calls.

Audits had not been effective in identifying concerns and it was not clear what action had been taken to prevent re-occurrence.

Fosse Healthcare - Leicester

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.

We carried out the inspection visit on 8 and 15 December 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available.

The inspection team consisted of two 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 information that we held about the service to inform and plan our inspection. This included information that we had received about the service as well as statutory notifications that the provider had sent to us. A statutory notification contains important information about certain events that they must notify us of. We contacted Healthwatch Leicestershire who are the local consumer champion for people using adult social care services to see if they had feedback about the service. We contacted the local health commissioners who had funding responsibility for some of the people who were using the service.

We spoke with six people who used the service and eight relatives of people who used the service over the telephone. We spoke with the registered manager, the regional manager, the area manager, the operations director and eight care workers. We looked at the care records of 13 people who used the service and other documentation about how the service was managed. This included policies and procedures, staff records, training records and records associated with quality assurance processes.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us that they did not feel safe because they could not be assured that staff would arrive to provide the care that they needed to remain safe. Comments from people's relatives included, "No I don't think he is safe, not really. I have concerns – we have been let down with calls." "No she is definitely not safe, they have missed calls and do not stay for the full time." Another person's relative told us, "We have a problem with them not arriving at all."

At the time of our inspection we were aware that there were investigations into late and missed calls being carried out by the local safeguarding authority.

Staff were aware of how to report any safeguarding concerns that they had about people's safety within the organisation and if necessary with external bodies. They told us that they felt able to report any concerns. One staff member told us, "Contact the office. If nothing got done I would tell someone higher. You keep going higher until something gets done." The registered manager had taken appropriate action when a concern had been raised with them. One staff member told us, "There was a problem. I reported it. They were on the ball and took statements." We saw that there was a policy in place that provided staff, relatives and people using the service with details of how to report safeguarding concerns. The provider was aware of their duty to report and respond to safeguarding concerns. However we saw that missed calls had not always been identified as potential neglect and reported to the local safeguarding authority in a timely way so that they could investigate them. We also saw that action had not been taken when concerns had been identified around people's medicines.

All relevant checks had been carried out on staff members prior to them starting work. We looked at five recruitment files. These records included evidence of good conduct from previous employers, and a Disclosure and Barring Service (DBS) Check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care services.

People could not be assured that they would be supported to take their medicines in line with the prescriber's guidance. People's relatives told us of occasions when their relative had not received their medicines. One relative said, "Carers recently took tablets from out of anywhere in the dosette box and we had to sort it out. We know they have not arrived on three occasions because the tablets have still been there." Another relative told us, "They missed two days recently which meant (relative) did not take any medication at all." Staff told us that they were not always given clear guidance about how to give people their medicine. One staff member said, "The tablets were the most problematic. Medication it was a nightmare." They went on to tell us that they felt that when they first joined Fosse Healthcare people were not safe due to lack of information regarding their medicines. Staff told us that they were now given more guidance with regard to supporting people to take their medicines but also said that the guidance was complicated. One staff member said, "Medication should be simpler, we are not nurses." The registered manager told us that they reviewed people's medicine records to check that people had received them as they should. However we saw that they records were not always kept up to date by staff members. This meant that there was a risk that people were not receiving their medicines as prescribed.

Where people had been assessed prior to support being provided they were protected from risks relating to their conditions. We found that for most people risk assessments had been completed on areas such as moving and handling, nutrition and skin care. However for some people assessments had not been in place when they first started using the service. Completion of these assessments would have enabled risks to be identified and given guidance to staff on how to minimise the impact their impact. Where people required specialist equipment to maintain their safety this was in place. Consideration had also been given to risks associated with the home environment. However these assessments had not always been completed at the time when people started using the service. This meant that there was a risk that they would not be protected from avoidable harm.

Staff understood their responsibility to keep people safe and protect them from harm. Staff were able to explain to us the measures they took to help people remain safe such as ensuring the environment was free from clutter and that they left people's homes secure after they had completed their care calls. We saw that staff were required to ensure that people had their safety equipment available to them when they left the care call.

Requires Improvement

Is the service effective?

Our findings

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 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.

The service had a policy in place to guide staff about the MCA and some staff had received training on the subject. Some people had a lasting power of attorney agreement in place regarding their care and welfare and finances. This is a legal agreement that allows another person to manage a person's finances or make decisions on their behalf with regard to their care. It was clear within people's records who had these agreements in place. We asked the registered manager to ensure that they had sight of this document when decisions concerning health and welfare or finance were made. They told us that they would.

We found that people's ability to make decisions and consent to receiving care had been considered. Where people had care plans in place we saw that there was reference to their ability to make decisions and understand information. We saw that where people were able to make decisions for themselves, this had been recorded. Where people required some support or reassurance around making decisions this was clear on their care plan. However where people were suspected of lacking the capacity to be able to make informed decisions for themselves a formal assessment of their capacity had not been undertaken. Records advised that people's relatives should be consulted to make decisions on their behalf without ascertaining if they had the legal right to do so. This meant that there was a risk that people's human rights would not be upheld. The provider told us that they had identified that throughout the service staff's understating and the implementation of the principals of the MCA were lacking. They had arranged for further training of staff to take place and a review of how people's ability to make decisions and consent to their care to take place.

People were supported by staff who had the skills and knowledge to meet their needs. One person said, "Yes they know what they are doing." Another person said, "It's a good service. Good carers." Staff told us that they received training when they started working at the service that enabled them to understand and meet people's needs. This included manual handling and health and safety training. One staff member said, "You have to do your training before you start your care work." They went on to say, "It's everything you need to know for the basic care." Staff confirmed that they shadowed more experienced staff members before they supported people on their own so they could understand their support requirements. One newly recruited member of staff told us, "The training has really helped. I had a really good teacher." We saw training records that confirmed that staff had received the required training. A staff member told us that they would like to receive more training around supporting people with dementia. The registered manager had reviewed staff's training records and identified if further training was needed. For staff who had transferred from other providers the registered manager had identified if they needed to refresh their knowledge and had booked them for further training. We saw that staff's understanding of the training that

they received was assessed. In one case we saw that a staff member had been recommended to complete further training and shadowing as they had not been able to demonstrate that they could fully implement the training that they had received.

Staff told us that they felt supported and guided to enable them to undertake role. We saw that there was an on-going program to complete supervision meetings with all staff. In some instances this was via telephone rather than face to face. The registered manager told us that they were aware of the recent pressures that staff had experienced and the effect this may have had on staff due to the new contract. They told us that it was not always possible to meet with staff in person at this time but completed telephone supervisions to ensure that staff felt supported and were given the opportunity to discuss concerns. Spot checks were carried out to ensure that they were competent to fulfil their role. One staff member told us, "I have had a senior come out about a month ago to watch me to make sure I know what I'm doing." Another staff member said, "I've had someone come out and do a check."

People were supported to have enough to eat and drink. One person said, "Yes they put my lunch in the microwave for me, or make me a sandwich depending what I fancy." Another person said, "Yes they leave a sandwich for me and make sure I have a drink." People's relatives confirmed this. However one person's relative told us, "They missed two days calls recently, so this meant (relative) had no breakfast on those days." We saw that people's care plans contained some basic information about people's meal preferences and guidance for staff to follow to support people to maintain their diet. At the time of our inspection there was a safeguarding investigation into whether staff had provided a person with a meal which may have been unsafe for them to eat.

People were supported to maintain their health. We saw that people's care plans contained information about their physical health needs. Staff were clear on what support people might need in case of emergency. They understood the need to contact health professionals on behalf of people using the service if they needed them to. One staff member told us that a person's nurse had been contacted when staff became concerned about the person's skin. Records reflected that staff had called for emergency healthcare when a person's health condition had deteriorated.

Good

Is the service caring?

Our findings

Most people we spoke with told us that care staff were caring and treated them with kindness and compassion. Comments from people included, "The carers are excellent." "Yes they are lovely." "I am extremely happy with them, the finest bunch of people." People's relatives confirmed this. One relative said "The carers are lovely." Another relative told us, "They are very caring." A third relative said, "When the carers come everything is spot on and as it should be."

Staff treated people as individuals and understood that people's care should be led by them. One staff member told us, "Everyone is different." They went on to tell us about how the time it takes people to complete tasks can differ depending on how they feel each day. Another staff member told us how they communicated the support they were providing to people. They said. "Discuss with them what you are going to be doing."

People were supported to maintain their independence. A staff member said, "If they want to make their own tea, you are there for that person, helping them." Where people had care plans in place they offered staff guidance around the things that people were able to do for themselves.

People were treated with dignity and respect. Staff were able to explain ways that they ensured people's privacy was maintained particularly when providing personal care to them. One staff member said, "Treat [people using the service] as you want to be treated yourself. I wouldn't want to degrade anyone." People were supported to be involved in the care that they received. Staff told us that they offered people choices and included them. One staff member told us, "Ask them, what they want to wear, if they are comfortable with the care." People's care plans offered staff guidance on how to offer people choices and include them in their care.

Most people told us that they were supported by staff who they were familiar with. One person said, "I usually have the same ones" People's relatives told us, "Yes I believe [person] generally has the same ones." However other people told us that they did not receive care from staff that they knew. One relative said, "No it is a big problem. I have told them my [relative] needs consistency to build a relationship up with these girls. We did have one shadowing a usual carer recently." Another relative told us, "Yes we do get the same carers most of the time. It has been a bit better lately but they do send ones who have never been before. I have to tell them what to do and where everything is." Staff confirmed that they usually supported the same people. One staff member said, "You have regular people you go to but cover if carers call in sick." They went on to say, "It takes time when people are new because it takes time for them to trust you." However another staff member confirmed that when they had first joined Fosse Healthcare they were expected to support people who were not familiar to them. The registered manager told us, that they were reviewing staff rotas and aimed to ensure that people were supported by staff that they were familiar with.

People were provided with information about the service and the care that they should expect to receive. People were given a service user guide when they started using the service. This contained information about what they should expect from the service and how they could make a complaint or get in touch with

someone from the organisation. We saw that senior staff checked with some people when they wrote their care plan to make sure they understood and were clear on how to contact the office or make a complaint. However we saw that in some people's records this section had been left blank. The registered manager told us that they would ensure that people were made aware of this when their care packages were reviewed.

Requires Improvement

Is the service responsive?

Our findings

Not all of the people that were being supported had had their support needs assessed. One person said, "My care plan has just been done." People's relatives confirmed that people's care plans were not always in place. One relative told us, "Fosse kept saying they were coming out. In the end the social worker has done her own and sent it over to them. There is no folder for the papers to go in, like with the last service. Staff can't follow it because there isn't one there yet." Another relative said, "Fosse did the care plan yesterday." A third relative told us, "We met them (Fosse) before they took over and they said they would come to do the care plan. The manager cancelled an appointment so it is still not done." On the first day of our inspection the registered manager told us that some people's care plans were still to be completed. We returned to the service a week later to complete our inspection and were told that not all of the assessments had been completed and that there were still ten people's assessments outstanding. This meant that staff were not sufficiently clear on what support people needed.

People's care plans did not provide the level of detail that staff required to ensure that they met people's needs. One person told us that staff were reliant on their guidance in order to understand their support needs. They said, "They know what to do because I can say what I need." One person's relative told us, "Staff need to clarify what needs to be done." Staff confirmed that they had not always been sure of what support people needed from them. One staff member said, "We were going in a bit blind." Another staff member said, "It was difficult when there weren't care plans." We saw that people's care plans contained some information about people's past history and what was important to them. For example we saw that one person's care plan stated that they still liked to do as much for themselves as possible. We also saw that they contained information about people's levels of independence regarding certain tasks. For example, where people required prompting or full support. However we saw that this information was not consistently completed in detail. The registered manager told us that some care plans were not as detailed as they would have liked. However, when the person's care plan was reviewed, they intended to ensure that more detail was included.

Where people's care needs changed we saw that care plans were not updated to reflect this change. We saw that one person's care plan stated that they received a lunch time call daily however, the call log indicated that they had not received a lunch time call on one day of the week that we reviewed. We asked the registered manager why the person had not received the call. They told us that the person no longer required a call one day per week as they now attended a day centre on that day. We saw an email from the person's relative that confirmed this. We saw that another person's call times had changed but that this was not reflected in their care plan. This meant that staff could not be confident that the information contained within people's care plans was current.

Some people were involved in the planning of their care. One person told us, "I haven't seen [care plan] yet but am happy with what we talked about. I am able to talk to carers and tell them what I need." We saw in people's care records that some people had agreed to their care plans and to the content. However it was not always clear how people had been involved in developing their care plans or that they had agreed to them.

People's care was reviewed to ensure that it continued to meet their needs. We saw that telephone reviews of care had taken place. People were asked their views on the care that they received. In one case a person had expressed that they did not wish to be supported by a particular member of staff. We saw that the registered manager had taken action to ensure that this member of staff no longer worked with them. We also saw that a person had expressed a wish to receive more support around meeting their social needs. This too was supported and their care plan updated as a result. We saw that people had generally expressed positive feedback about the service as part of their reviews. However we saw that some people had identified that they were not receiving their call times as they should. It was not clear what action had been taken to address this.

People did not receive their care at the times that they wanted . When people had been told what time they could expect their care staff to arrive to support them they were not assured that this time would be adhered to. One person said, "It can be as late as 10pm when they get here." One person's relative told us, "They keep arriving early, 6.45am this morning, for a 8.30 call. In fact I have cancelled them for this weekend so we don't have to get up early." Another relative said, "It should be 10.00 am to 10.30 and it can be as late as 12.00." A third relative told us, "The stress of them changing times and not turning up at all is making me very upset." All of the people that we spoke with told us that they were not kept informed if care staff were running late. The provider told us that they were working with people to identify the times that they wanted to receive their care calls and then staff rotas to reflect these.

These matters constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not established an effective system for handling complaints. People and their relatives told us that they had tried to lodge complaints with the registered manager but that they had not been listened to. Comments included. "I have complained to the office staff and have been fobbed off." "I have spoken to different people in the office. They say they will 'make a note' but nothing is done about it." "I recently rang and spoke to the manager. She said she would call back by the 7th but didn't. I had to ring her. She said she had passed my complaint to the area manager." We saw that the provider's complaints procedure was included in the service user guide that was provided to people when they started using the service. People were asked to confirm that they were aware of how to complain as part of the setting up and reviewing of their care plan. We saw that this section was not always completed and as a result the provider could not assure themselves that people understood how to raise a complaint if they needed to.

We saw that the provider had allocated a dedicated staff member to review all of the complaints received and respond to each one. We saw that the provider had taken action to address some complaints that had been received. At the time of our inspection we were told that each person had been contacted and offered assurances that their complaint would be addressed in line with the provider's policy. People's relatives confirmed that they had received contact.

The provider had sought feedback from people using the service. We saw that in December 2015 they had sent surveys to people. We saw that people had expressed a wish to receive a rota of staff who would be providing their support each week. The registered manager had written to people to explain that this would be commencing and that they had listened to people's feedback. The registered manager told us that since having secured the large contract recently they had not been able to provide people with reliable rota's and had temporarily suspended this service. They told us that they intended to re-instate giving people rota's in advance in the new year.

Requires Improvement

Is the service well-led?

Our findings

The provider did not have an effective system for monitoring call times and ensuring that people received the care that they needed to remain safe. A person's relative told us that they felt the need to visit their relative daily because they could not be confident that their relative would receive the care call that they needed. Staff were expected to log into an electronic call monitoring system when they arrived at people's home to provide care and then again when they left. We asked to see the records of these calls. We saw that for the majority of people being supported staff had not logged into the system. This meant that there was no reliable way of checking if they had received their care call or not. The provider could not be sure that people were receiving the care they needed to remain safe.

There were not effective systems in place to review the care that people received and to check that these were in line with their assessed needs. On the first day of our inspection we were told that most people's daily records and medication charts for November remained in their homes and had not yet been collected to be checked. We asked that these records be retrieved so that we could check them on the second day of our inspection. On the second day of our inspection we were told that three peoples records were still in their homes. The registered manager told us that they planned to collect records from people's home to review them in the first week of each month. This had not happened. The registered manger could not demonstrate that people were receiving the care that they needed.

Systems to check the quality of the service that people received were in place but these were not robust. We saw that a person's medication records for November 2016 had been audited by a senior member of staff. The audit had not been dated or signed so the provider could not be sure who had completed the check. The person who had checked these had identified that staff had not consistently signed the record to confirm that they had supported a person to take their medicines. However we saw that it was not clear what action they had taken to ensure that the person had received their medication and to prevent further omissions in the records. They had not made the registered manager aware of these concerns. The registered manager was unable to locate the audit for October 2016. People not receiving their medicines could be classed as neglect and this should be reported to the local authority safeguarding team. Since our inspection the provider has trained three staff members to audit the records. They have implemented a new medication error reporting system, written to each staff member providing them with guidance around medication administration and recording and reporting. They have also introduced a new system for checking that staff are competent to administer people's medicines.

These matters constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not feel that the service was well led. A person's relative said, "We can't fault the carers. It's the management which needs sorting out." Other comments included, "I don't know the manager but I don't think it is well managed. They don't know how to organise the staff, or themselves. Staff don't know what they are supposed to be doing." "They are disorganised and I am totally frustrated with them."

People told us that they were not always able to speak with someone at the service when they wanted to. A relative told us, "They are not very helpful. They never ring back." Another relative said, "You ring the office and they say they will ring you back but don't. They tell fibs, when we have cancelled a carer they haven't passed the message on." A third relative told us, "We waited three hours [for a carer to arrive]. We couldn't get through because they wouldn't answer the phone." The provider told us that they had been aware that there had been issues with people not having their enquiries dealt with in the time frames that they would like. After the first day of our inspection the provider had written to every person using the service to apologies for any disruption in service that they had experienced and giving them a clear point of contact that they could use to raise concerns. . Relatives of people using the service confirmed that they had received this letter.

Most of the staff that we spoke with felt that they were supported and could contact support if required. Staff said, "They are really helpful on the phone. I really like this company." Another staff member said, "The manager and the staff in the office are really helpful." They told us that, "There is always someone on call to help you out." The provider told us that staff had expressed difficulties with contacting the on call senior staff member. As a result of this feedback they had implemented a second staff member to cover on call. They told us that this had been successful and staff now expressed that the on call system was effective.

Staff also received support via staff meetings. We saw that staff meetings had taken place during the week of our inspection. The minutes of these meetings reflected that the provider had explained changes within the service. They had asked for staff feedback and made efforts to address staff concerns. They had explained to staff the importance of using the electronic logging in systems in an effort to increase staff's usage of it. Staff were reminded of the support systems available to them and how to use them. A copy of the meeting minutes were sent to all staff members including those who did not attend.

The provider had recently taken on a large contract to provide support to people who had previously received support from other providers. Staff confirmed that there had been a lot of changes. One staff member said, "It was a massive change, very confusing for service users and staff." Staff told us that they felt things were more settled recently. One staff member said, "It's settling down quite a lot." Staff also told us that they were receiving their rota further in advance than they had the previous month. They told us that this was a sign of improvement and that call times were becoming more organised. One staff member said, "The rotas are becoming more regulated. I'm working with the same people a lot more."

The provider had taken action to make improvements to the service as a result of identified failures. Incentives had been introduced for staff who were meeting the expected standard of practice particularly around use of the electronic call log in system. Where staff were not meeting the expected standard the provider told us that they intended to ensure that staff were supported to do so via the provider's disciplinary process. The provider also told us that they planned to employ staff members who would be charged with monitoring the electronic call log system. The aim was that they would be able to identify in "real time" if a person had not received their call. This would enable them to arrange for the call to take place and address the issue straight away. The provider had reviewed recruitment and retention records and had implemented changes in order to improve these.

The provider has systems in place to ensure that staff were aware of their responsibilities. Staff received a handbook when they started working for Fosse Healthcare. This was to make sure that staff were clear on their role and the expectations of them. We saw that staff could be confident that a fair process would be followed. One staff member told us, "There are some shocking staff that ring in sick. I have spoken to Fosse about that. They said they will sort it." We saw that increased staff sickness was being monitored via the relevant human resources processes. The registered manager told us that they had identified that not all

staff were working in line with company expectations and that they were pursuing disciplinary action with these staff members.

Fosse Healthcare - Leicester had sub contracted some people's support packages to other providers. We saw that they understood their responsibility for ensuring that the sub-contractors provided a level of care that met people's needs. Subcontracted organisations were required to provide assurances that people were receiving their support at the agreed times and that their care plans contained the information required to meet people's needs. We saw that the registered manager and other senior staff planned to visit the sub contactors to audit their processes in order to assure themselves that people were receiving safe and effective care.

Providers are required to inform the Care Quality Commission of significant events that happen in the service, such as allegations of abuse. The registered manager was aware of their responsibility to submit notifications when such events occur. We identified that notifications had not been submitted. We discussed this with the registered manager who told us that they had identified that the notifications were required but had not prioritised completing these over addressing other issues within the service. They told us that they would complete these the following day. We later checked and found that these notifications had been appropriately completed.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care needs had not been assessed and did not reflect their needs and preferences.

The enforcement action we took:

Issued warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager had failed to adequately assess, monitor and mitigate risk relating to health, safety and welfare of service users and maintain complete and contemporaneous records.

The enforcement action we took:

Issued warning notice.