Promedica24 UK Limited

Promedica24 UK Ltd - Reading

Inspection report

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02 March 2016
04 March 2016
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09 March 2016
15 March 2016
16 March 2016

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on the 02 March 2016 and was announced to ensure the people we needed to assist with our inspection were available. We found that the provider had moved locations from 400 Thames Valley Park Drive, Reading, RG6 1PT, to Cassiobury House, 11-19 Station Road, Watford, WD17 1AP. This had been completed without the correct registration processes being completed. These concerns were now being addressed by the provider. This was the first inspection for this location. We carried out home visits on four separate days to meet and obtain feedback from people who used the service, their families and live in carers. We also held interviews over the phone. Promedica24 UK Ltd - Reading provides live in carers to support people who live in their own homes. At the time of our inspection Promedica24 UK Ltd - Reading were providing care to 78 people.

There was not a registered manager since 17 November 2015 the manager at the time of our inspection had just applied to become the registered manager. A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run.

Accidents and incidents were recorded by staff but no follow up or risk assessments were completed to keep people safe. There were no systems in place to monitor risk to people's health and well- being.

People told us that they felt safe, happy and well looked after in their homes. Staff had received training in how to safeguard people from abuse. Staff would report concerns to the manager and the family. However staff were not aware of the process for reporting to the local authorities. The recruitment processes were not safe and effective. There were not sufficient staff resources to always cover staff when required.

Medicines Administration Records (MAR) were not always completed properly and we saw no evidence that medicine audits had been completed or staff received competency checks in medicine administration.

There were no systems in place that enabled staff to identify trends and patterns emerging to prevent risks and improve the service. The provider did not have effective governance in place. There were no systems to audit, monitor and drive improvement.

People knew how to complain. However there were no effective and accessible systems for identifying, receiving, handling and responding to complaints from people who used the service.

Relatives and people were positive about the skills, experience and abilities of staff who worked in their homes. Staff received four days training in Poland, however the training did not cover all areas of people's needs and we saw no evidence of additional training for staff to enable them to support people's needs. Staff had not received regular supervision to discuss and review their development and performance.

Staff had developed positive and caring relationships with the people they cared for and clearly knew them very well. People had been involved in the initial assessments of their care but not everyone received regular reviews of their care and support.

Care was provided in a way that promoted people's dignity and respected their privacy. However not all people received personalised care and support that met their changing needs and took account of their preferences.

People were supported to maintain good health and had access to health and social care professionals when necessary. They were provided with a healthy balanced diet that met their individual needs.

Staff made considerable efforts to ascertain people's wishes and obtain their consent before providing personal care and support, which they did in a kind and compassionate way.

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 always safe.

People were not always kept safe by staff trained to recognise and respond effectively to the risks of abuse.

Potential risks to people's health and well-being were identified but were not managed effectively in a way that promoted their safety.

Safe and effective recruitment practices were not followed to ensure that all staff was fit, able and qualified to do their jobs.

People were supported to take their medicines by staff. However no audits were completed to ensure safe practice.

Is the service effective?

Requires Improvement

The service was not always effective.

Capacity assessments and best interest decisions had not been followed in line with the MCA 2005 act.

Staff were not always supported to help them meet people's needs effectively.

People were provided with a healthy balanced diet which met their needs.

People had their day to day health needs met with access to health and social care professionals when necessary.

Is the service caring?

Requires Improvement

The service was not always caring.

Not all people and their relatives were involved in the planning, delivery and reviews of the care and support provided.

People were cared for in a kind and compassionate way by staff that knew them well.

Care was provided in a way that promoted people's dignity and respected their privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Not all people received personalised care that met their needs and took account of their preferences and personal circumstances.

There was not detailed guidance made available to staff to enable them to provide person centred care and support.

People were supported to maintain interests and hobbies.

People and their relatives were confident to raise concerns. However there were no systems in place to log complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were no effective systems in place to quality assure the services provided, manage risks and drive improvement.

Staff understood their responsibilities but not all staff felt supported by the management team.

Staff were working more than there contracted hours and did not have the support to ensure they received adequate breaks.

Promedica24 UK Ltd - Reading

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 2012, 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 carried out on 02 March 2016 by two Inspectors and was announced. We also visited people in their home on the 08, 09, 15 and 16 March 2016. We spoke with two social workers and a community nurse. We also reviewed other information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with seven people who used the service in their own homes, eight relatives, seven staff members, the manager and director and two care managers. We also received feedback from health and social care professionals; we looked at care plans relating to seven people and six staff files.

Inadequate

Is the service safe?

Our findings

Staff were provided with safeguarding adults training as part of their induction. Staff told us if they had any concerns that they would contact the family and their managers. One staff member said, "I would always report any concerns to the manager." One relative said, "When [Relative] was not feeling well the staff contacted us but we were not available and they didn't know what to do. "The relative told us that the staff know now as we make sure they know who to contact. This meant not all staff knew who to contact when required.

There were no processes in place to ensure that people were safe from the risk of abuse or protected from reoccurring incidents or accidents . Incidents were not recorded or maintained to assist in identifying trends and enabling staff to put remedial actions in place to mitigate the risk. When we asked the manager to review copies of the latest log, they told us, "There isn't an incident log. It is in the process of being developed." They told us that we would need to go through each individual file and retrieve any incidents from those recorded in people's daily records of care. However when we looked at these archived records they were out of date and had not been reviewed since the beginning of the year. This meant that the provider did not have a system to help them recognise people's changing needs and patterns to help prevent accidents and incidents.

The manager told us however that no incidents had been reported to them since they started four weeks prior to the inspection. One person who the manager told us was a high risk of falls due to their condition had sustained a number of falls. Between October and December 2015 they had sustained 13 incidents which recorded injuries such as grazes, scratches, and marks. None of these had been reviewed; the last documented review of their care needs was at the beginning of October 2015 prior to these incidents. None of the incidents reported to the care manager had prompted a review. This meant that people's changing needs may not have been recognised and risk may not be identified there had been no regular monitoring to ensure people were kept safe.

We found that one person had experienced a nose bleed which had not been managed well and the cause of which had not been followed up by the care manager even though this was raised by the person's carer. The care records show that the carer tried to gain help and support but had been unable to get any help. The carer had used a tampon to stop the nose bleed as they were unable to get any better advice. We saw no evidence that any of these issues had been risk assessed to reduce the risk of this happening again. The person's changing needs had not been identified or responded to.

We identified safeguarding concerns were not followed up or assessed to mitigate the risk to a person's safety and welfare. In one person's care plan it had been recorded as, "Safeguarding Concerns: Person is a vulnerable individual but will be well supported in their home. Staff were to report any concerns immediately to Care Coordinator or Care manager." There was nothing to identify what these concerns were, other than leaving the reader to assume the person was vulnerable because of their condition. There were no systems in place for the care managers to report concerns. For example, one care manager whose area covered three or four different counties, was not aware of the reporting arrangements for each, and did

not have a copy of the local safeguarding policy for each county. This meant that people were not protected from the risk of potential harm or abuse.

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

The manager told us that care plans are reviewed on a quarterly basis, however would be reviewed when a person's needs changed. They told us, "It is very much customer led. The process is to complete an incident report and body map, and to contact the care manager and inform them of the incident. The care manager will visit and will review the incident and if needed the person's needs, will be updated and noted in the care plan that they have visited." However, we found this process had not been followed, this meant there were no adequate systems in place to manage people's risks, and people may have been at risk of harm or injury.

One person used a treadmill to support their mobility. However, staff had not assessed the activity or equipment and the person subsequently had a fall whilst using the equipment that resulted in an ambulance being called due to them sustaining an injury. The staff member had previously documented they had fallen from the treadmill three days prior to this; however, neither incident prompted a review. This meant although the staff member had documented the fall the risk had not been reviewed and appropriately risked assessed and had led to a further accident.

We found that incidents were not reviewed for patterns themes and trends to mitigate the risk of repeated falls or injuries. This meant that people were not always protected from harm or unsafe treatment because a system of reporting, reviewing and identifying risks to people was not robust or consistent. Identified risks had not been safely assessed and managed. For example one person had dysphagia, but there was no training provided to the staff or guidance on best practice to ensure they received safe care. There were no comprehensive assessments in the care plan for assisting them with eating and drinking for example. We found no evidence in the care plan of referrals to Speech and Language Therapy team (SALT) or the dietician to seek advice.

Incidents were not investigated by either the care manager or the registered manager. We found that staff had recorded incidents such as; people were found to have grazing, small injuries to knees, a yellow bruise to a shoulder, and on one occasion five yellow bruises. None of these had been followed up by a care manager to either determine their cause, or to look for a way to mitigate the likelihood of them recurring. Staff recording of these injuries was poor. In October 2015, one staff member had hand drawn a body map and drawn in the location of two bruises. They had then noted down, "Two red bruises [rear right side] probably made when [person] walked around like usual because of their disease." No review had been undertaken and a member of the management team had not sought to undertake an investigation to ensure they were not being harmed by poor moving and handling or possible abuse. We asked the manager about this but there was no information available for them to give a reason to why these incidents had not been properly managed. One staff member we spoke with who had reported changes to a person's needs told us that a review had not taken place and they were left managing the situation.

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

Staff were recruited from the European Union. The provider told us that they were interviewed, inducted and trained in their own country where references were collected. When we review the staff files we found that both British and European criminal records checks had been completed and the manager had seen evidence of identity. However, managers had not checked and verified people's references to ensure they were valid. In one example, one staff member had recorded for a period of seven years they had worked for a family as a private builder. However when the reference had been returned, the referee had recorded they

had only known them, "For a few weeks." The manager had not identified this as a concern, and did not follow up on this information. Subsequently, the staff member worked with a substantial gap in their employment history. We found also that other staff had unchecked gaps in the employment history. A second person was found to have gaps between 2012 and 2014 which were unchecked. This meant that the provider could not ensure that people were sufficiently skilled and suitable to work with people, as they had not carried out robust recruitment checks.
There was no cover provided for staff to attend training whilst on a contract. For example we asked the manager if we could meet some carers when we came to the office to inspect. We were told that this was not possible as they needed to be at the person's home providing care. This was a concern that there was no system to provide cover, or support staff if they needed to go home in an emergency or if they became unwell for example. We spoke with one care manager who told us that they would provide cover if someone had become unwell or had to go home in an emergency.

We spoke with one staff member who did need to go home early due to personal circumstances. However, they were unable to leave as there was no one to replace them at short notice. The staff member was emotionally upset but they told us they had to stay as the person they supported could not be left on their own. They were hopeful that by Friday they could leave but this was three days away. The person they cared for had described to us how upset they were and how they had comforted the staff member. Another staff member told us that they had to stay for an extra couple of days because their replacement had not been organised properly. They said, "They [Promedica24] were always leaving things to the last minute. It would be nice to know who is coming and for what time." This meant that staff were not always supported and there was not an adequate system in place to cover staff at short notice.

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

People were supported by staff to take their medicines. Staff and family members told us that they reminded people to take their medicines on time. We found that medicines had not always been recorded properly on Medicine Administration Record Sheet (MAR) We saw that staff had used crosses as opposed to the key to identify why medicines were not administered, there was no documented reason given why this medicine may not have been given we noted these issues in four MARS we looked at. We found one person who had been prescribed medicine to manage excessive salivation. They were to have this three times daily. We found that on three occasions this had not been given. There had been no consideration of the impact of this omission. There was no system to audit medicines, not all staff received competency assessment by their managers to ensure they had followed best practice. One care manager we spoke with told us that they carry out competency assessments. However depending on the time they arrive at the person's home, they may not be able to see medicine be given. We saw no evidence of further training or guidance when errors had been made in the recording of medicines. People were not protected from poor practices that could lead to people not receiving their medication. There were no adequate monitoring processes in place to keep people safe.
This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) 2014.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act (2005) provides a legal framework for making particular decisions on behalf of people who may lack 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. Where 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 able to verbally demonstrate they understood the principals of the MCA.

We checked whether the service was working in line with the principles of the MCA and we found they were not. For example, details of a person's Power Of Attorney (POA) were not held on file. We found no evidence to suggest that people who stated they have POA had one for health and wellbeing. One person's relative signed the person's care agreement. Where they had signed staff had recorded, "[Relative] applying for full guardianship." At the time of signing this was not in place, and they had agreed to care services on their relative's behalf.

All staff we spoke with understood about the importance of choice and people confirmed that staff always asked their permission and encouraged them to be involved and make decisions. One staff member said. "Choice is very important it's [Name] house, it's their life and I respect that. I make sure they feel comfortable," However where people lacked capacity, we did not see best interest decisions in place. One carer said about the person they supported with dementia, "if they want to go to bed at 1800 I would stop them as it's not good for their routine. The staff member made it clear that they would not physically stop the person but would dissuade them. This meant that decisions were being made to suit the routine that the staff member had decided was best and was not about the person's choice. We saw care plans that stated person does not have capacity to make decisions and the family will make decisions for them but no record that they had the power of attorney to make these choices. This meant that not all decisions were made in people's best interest.

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

We saw training for staff members that formed their induction. The induction was a corporate based induction delivered over four days in the organisations training department in Poland. It is classroom based, and a copy of the training pack was available to review. The training package covers the basic areas of care, such as nutrition, hydration, MCA, dementia awareness, first aid, medication. However, where people had needs that were more complex, such as continence, skin integrity, motor neurone disease, epilepsy, we found that additional awareness training had not been provided.

The staff we spoke with felt the training was very intense with four full days. One staff member said, "We had so much to learn and remember. It was too much in four days." They also commented, "I would like to have more training I would like to know how to care better for people with dementia." The person being supported by this staff member had dementia.

Staff also told us they would like more training to be able to support people better with their individual

needs. We saw staff that supported people with specific needs and had not received the additional training. We did not see any evidence that staff had proficiency checks to make sure their skills were adequate to provide good care. One person's assessment stipulated that the staff required training in pressure sores. However a record of their training provided did not include this. One care manager said, "That they did not formally observe practise but asked a series of questions." We saw no evidence that all staff were receiving competency checks to ensure best practice. This meant that the provider was not ensuring that all staff received relevant training and systems were not in place to ensure all staff had their skills checked.

We asked about staff meetings and were told by the manager that the care managers would visit people and the carers monthly to make sure that people were happy and that staff had a voice. This visit could also be used to spot check the environment and check that staff worked using best practice. We were told by some staff that they were regularly in contact with their care manager even if this was completed over the phone. However there were other staff who had not had the same amount of support. This meant that people were not supported properly by the provider to ensure best practice.

When starting work in the UK staff received a hand over from the previous staff member and were then allowed to work unsupervised. One person said, "I was told from the beginning that the care manager would visit at least once a month and to be honest I have only seen them once since August." A relative told us, the communication from the office is not good. "One care manager said when they arrive to visit they can only spot check what they see." The manager told us that people received 24 hour hand overs but staff we spoke with confirmed that most handovers were up to four hours. One person said about their handover, "The [Carer] was flying out the door after 20 minutes as their taxi was waiting." This meant there were not always adequate hand overs for staff.

Some staff we spoke with were unsure if they had received formal supervisions to address areas of concern and provide support where needed or development where required. All staff received regular calls from Poland to check whether they were ok or needed equipment like gloves for example. One person who had received their supervision had asked for more training but told us this had still not been made available. Not all staff received the support, training, professional development, supervisions and appraisals that were necessary to carry out their roles and responsibilities effectively.

We had mixed feedback from relatives about the skills the staff had. One relative said, "At first they didn't seem to know what they were doing but they were willing to learn and they are really good now." This meant that some staff were taking guidance from family members about how best to support the person's needs this could lead to poor practices being used. However, people we spoke with were positive about staff and told us they had made a huge difference to the people they supported. We were told by the manager that all staff employed had a previous back ground in care; we found this could include people who had looked after relatives who needed support. This meant that they had experience looking after a relative, but the only training they may have had would have been the four days training when they started to work for Promedica24.

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

People were supported to have healthy balanced meals prepared by staff and themselves where able. One person said, "[Name of carer] cooks just like I use to and we plan our meals together." People we spoke with were supported to make shopping lists and go shopping for food. Everyone felt their preferences around food were met. One relative said, "My [Relative] helps with the cooking of the meals which they would not be able to do on their own." One person said, "The food is lovely."

People were supported by staff to attend GPs and hospital appointments. We saw evidence of visits attended recorded in daily notes. People told us they go to the GP's surgery and were supported to attend appointments. One staff member said, "I always contact the pharmacist to make sure their medicines are correct and ensure that we attend their appointments. "We spoke with a district nurse who told us that the Promedica24 staff they had met had been very professional and had followed the guidelines they had set to care for a person under their care; they told us they were very impressed with the person's recovery.

Requires Improvement

Is the service caring?

Our findings

People were cared for in a kind and supporting way by care staff living in their homes. One person said, "They provide a good service; all the staff have been good." Another person commented, "The carer is absolutely brilliant they are so kind and gentle, they have a wonderful heart I can't fault [Staff name]."

We saw kind and considerate interaction between staff and people for example, We observed one staff member asking if it was ok to move their walking frame whilst they showed us their daily notes and reassured them they would put it back once finished. Another member of staff who had to give some personal care asked us to leave whilst this was done, this demonstrated that the staff maintained the person's privacy and maintained their dignity.

We observed that staff and the people they supported had developed good relationships and staff demonstrated that they knew the people they cared for. A family member said, "The staff have become like family." All staff we spoke with told us that they are always asking what the person wants and make sure they are happy.

Staff were able to tell us about how to maintain people's dignity and privacy and gave examples of how they promoted peoples independence from encouraging people to make their shopping lists to encouraging people to do what they were able and supporting them when required. We saw where one person had become confused and needed to have things continually confirmed the staff member said I am really happy to go over things as many times as needed because they feel more reassured when they know what is going on.

We spoke to one relative who told us, we have peace of mind now and know that our [Relative] is in good hands. The Staff are excellent and have exceeded our expectations." One person said, "I am happy with the care I receive. The staff are really kind."

All though initial assessments were completed for people who used the service, we were told by people and staff that reviews of peoples care plans were 'hit and misses. The care plans we viewed had not been updated although there had been changes to some people's needs. We received mixed feedback about how involved people were with their care. We were told that the care manager would sit down with people to discuss any issues or changing needs. We spoke with people and their families and were told this did happen. However, this did not reflect everybody's experience. One relative said, "The care manager never visits." The staff member confirmed this. Care plans we looked at had not been regularly updated and contained incorrect information. This meant not all staff felt supported by the provider and people's changing needs had not always been reviewed. This lead to incorrect information in people's care plans.

Requires Improvement

Is the service responsive?

Our findings

People confirmed that they had received an initial assessment and the care plan was completed with the person and their families if appropriate. Care plans gave a brief commentary about a person's history, preferences and so on, but were not person centred. For example, in one person's care plan it records that they have a wash at the sink in the morning. This is a statement with nothing to describe how the person likes to be washed. There was no guidance to the persons preferences around how they would like this to be done

Staff did not have access to detailed guidance about the people they supported for example we saw one care plan that had changed and did not reflect the care needs of the person. One staff member said that the care plan they had been sent must be an old one because it did not reflect the person's needs. They confirmed that they had told promedica24 about the changes but this had not been reflected in the care plan, no review had been completed. Care plans contained risk assessments about health and safety of the home but there were only generic risk assessments in place. For example, people who had experienced falls, there had been no reviews to reduce risk and no guidance for staff on how to provide care. One care manager told us, I don't feel confident in completing risk assessments." This meant that staff were left to manage changing needs that may require further training and guidance. One staff member we spoke with had to work more hours due to the persons changing needs. People were not supported to have their needs regularly assessed.

We had two copies of a person's care plan that had been reviewed by the same Care manager on the same date. However there were differences in the care plans. For example, the address for the person was different on each copy. There was information about the person's behaviour that was not on both copies. Under the heading personal care one care plan stated person is able to shower independently but needs to be reminded to wear clean clothes the other care plan stated the same but had in addition 'supervision to make sure that with their erratic movements that they do not injure themselves or fall. Before showering [Name] will need prompting to sit down before getting undressed so that it (The words written in care plan) does not become unbalanced.' Under social needs one care plan states they go to the yacht club reads newspapers and like shopping. The other was completely different it stated that they enjoy going to the gym, going into town, watching films at the cinema, going to church and eating out. There was no way for us to know which care plan was correct and they were both reviewed and dated by the same person and on the same date but were different and had different instructions for managing the person's needs. We were told that this had been a mistake that was corrected and that the care plans in people's home were the correct copies. We were also told by the care manager that these copies should have been deleted but we were still sent a copy.

Care plans we saw in people homes were last updated may 2015 and had incorrect details for example the wrong manager was named and one person's care plan stated that the person may get up once during the night however the person behaviour had changed they were now getting up several times through the night and we saw daily records that noted they had been up twelve times in one night but the persons needs had not been reviewed.

Upon assessment of a person's needs, the care manager and family agreed how many care hours were required and whether they required the support of one or two carers. Where two staff were required, the manager told us that a local care provider provided a carer to support with tasks such as moving and handling and bathing. However, when we spoke with the care manager about how they attributed hours to a person's care, they told us this was based on a blanket level of hours. They said that they did not take account of tasks such as repositioning people frequently, continence needs, or other care tasks. This meant that the assessed level of care provided may be less than what a person actually required. This would also impact on staffs working hours.

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

People we spoke with knew how to complain and there were contact details provided within the care plans. Some people we spoke with told us they had raised concerns about the carers that had been chosen for them due to compatibility issues and in both cases we were told the issues had been resolved quickly and to their satisfaction. However, we found that there was no effective process in place for complaints. For example, there were no complaints logs. We were unable to see if any complaints made had been investigated and where necessary the appropriate action taken. There were no records kept at the Watford office. The manager told us that there are no audits in place and that they should have a full set of policies and procedures in place by the 11 April 2016.The provider did not have an effective and accessible system for identifying, receiving, handling and responding to complaints from people who used the service.

This was a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) 2014.

People were supported to maintain interests and attend church for example. One person we spoke with who loved gardening confirmed the staff member had been chosen by promedica24 to match their interests as they were a keen gardener also. The person was happy with this as they needed to be supported with their gardening. People confirmed that they were supported to maintain interests. For example people told us that they were supported to go out when they wanted to the shops for example.

Requires Improvement

Is the service well-led?

Our findings

Not all staff we spoke with felt supported and none of the staff, or relatives and people we spoke with knew who the new manager was. One staff member said, "I don't feel supported." Another told us they felt let down and isolated. This was because they had no social outlet and not much contact from the provider. Another staff member said, "Care manager doesn't call me often. I am a little disappointed and feel alone. I am not supported."

There had recently been a change of provider with the current management structure being newly appointed. The provider assumed ownership of the organisation in December 2015 and the manager was appointed four weeks prior to our inspection. The manager told us their first priority was to evaluate the current quality of care the service provided to people.

We asked how they monitored and evaluated the service to make improvements. We were told that there had not been any quality assurance in place when they had arrived, but they had begun to implement this. The manager told us that since starting they had arranged for an independent review by an external auditor to highlight areas that required improving. They were developing systems that would enable them to monitor and review incidents and injuries in a more robust manner. However at the time of the inspection, we found there were minimal systems in place to monitor and improve the quality of service people received. This meant that although the new management were actively working to bring change to the way the service was provided. They had not had time to implement and review the changes. At the time of our inspection there had been little done to monitor and improve the service provided. However, on the 04 April 2016 we met with the manager and provider to give written feedback on the inspection and we found evidence that changes were being implemented.

We saw that where incidents happened, staff had completed body maps. We spoke with the manager about the inconsistencies in incident reporting and investigating. For example there had been falls and other incidents such as unexplained bruises. We found although these had been identified and reported, there had been no record kept of what actions had been taken to investigate and assess the risks to ensure people's safety and wellbeing. The Provider told us they were aware that there needed to be processes in place and they had identified there had been no effective processes in place to help improve the service. They said, "When I opened the cupboard to look for files I could hear the echoes coming back."

We were shown a range of new documents that they were implementing that would assist to monitor and audit the service. There were no systems that enabled people to see trends and patterns emerging to prevent risk and improve the service. The provider did not have effective governance in place. They told us that the model of care provided had been developed in another European country where the systems and records were not required. They told us that they were constantly developing their governance system but accepted one was not in place at the time of the inspection.

We saw workbooks were now in place in some of the homes we visited which would allow them to monitor and audit peoples care. This showed that they were now responding to areas of concern raised in the

independent review. However as stated these changes were not fully in place and we were unable to judge how effective these systems being implemented would be. Although there was recognition that there were fundamental changes required and we saw evidence of plans for better policies and changes to the way records are kept. We found that people's risks were not being addressed and people's changing needs had still not been reviewed.

There were no regular assessment or reviews of people's changing needs to ensure that there were sufficient staffing hours provided. We were told by the manager that the staff they employed from Poland were self-employed and contracted to work 38 to 40 hours a week and were provided with breaks. We found staff who worked in excess of 70 hours a week. We found staff were unable to leave the home or go out for a break due to the person's needs. We were told by staff they could not leave people they supported unsupervised. This meant that they were permanently on call and needed to respond when required and they required cover to take their break and this was not always provided.

We sought professional advice about the staff employed by Promedica24 and found that from an employment perspective staff are to be provided with the same basic rights as all workers. They are classed as employees and are not self-employed if they work on a regular basis at set times under the direction of their employer. This meant that staff basic rights were not protected and staff were working too many hours.

One staff member told us that they work from 0800 to 2000 with a two hour rest break each day. However at the time of inspection the provider had not ensured adequate cover had been arranged to make sure the staff member had their break. The staff member worked seven days a week and they also had to respond through the night to assist the person they supported. The person's needs had changed but had not been reviewed. Other staff we spoke with told us that they worked more hours than they were contracted to work. One staff member who was unhappy with the amount of hours they were working told us that they had spoken to previous management about this but were told, you are the live-in carer that is your job.

Records relating to care and treatment were not always up to date and did not always reflect the person's needs. Records were not maintained at the office for example we were not able to see records of auditing. We asked about what plans the provider had to improve the service and were told that there had been a meeting between the provider and manager to discuss and review their action plan to improve the service. We were told there had been minutes completed for this meeting but were not available to us when we requested because they could not be located. This meant that records were not properly maintained or updated when required.

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

There was not a registered manager in place when we inspected and Promedica24 were in breach of their registration conditions. However registration confirmed that their application had now been received. The service did not demonstrate good management and leadership. There was a manager in post however they had just submitted their registration to CQC as required. The provider had moved from a different address without informing CQC. They had been requested on numerous occasions to submit an application to register, however they failed on several occasions to correctly complete the documentation.

The management team had not ensured that staff were supported or were able to work in an open and supportive environment. We had mixed feedback with regards to staff feeling supported some staff told us they felt supported but other staff felt isolated and not listened to. This did not promote an open inclusive culture. Staff were not able to attend team meetings to discuss matters relating to the service, share knowledge or discuss shared experiences. The deployment of staff meant that they were unable to leave the

person they cared for. However, consideration had not been given to the use of technology such as conference calling as a method to communicate.

We asked the provider and manager to show us a copy of their service improvement plan; however they had not developed one yet that they could share with us or staff. There had been no annual surveys or feedback forms sent out to gain feedback from people who used the service, family members or staff. This meant that there were no systems in place to drive continuous improvement, identify and recognise innovation or have a shared understanding among the staff team of what good care looked like. As each staff member worked in isolation with little support or direction, the approach to care was based very much upon each staff members view and experience, as opposed to an organisationally led, monitored and robustly governed service. The new management talked to us about the changes they had planned and this included telephone monitoring to ensure they had feedback from people that used the service.

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 care and treatment of the service user must be appropriate, meet their needs, reflect their preferences Carrying out collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users must only be provided with the consent of the relevant person.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Assessing the risks to the health and safety of service users of receiving the care or treatment, doing all that is reasonably practicable to mitigate any such risk and ensuring that persons providing the c are or treatment have the qualifications, competence, skills and experience to do so safely. Ensuring the proper and safe management of medicines.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes must be established and operated properly to prevent abuse of service users

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person must establish and operate effectively an accessible system for receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of regulated activity.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements in this part. Assess, monitor and improve the quality and safety of the services in the carrying on of the regulated activity. Maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to

carry out the duties they are employed to perform.

There should be procedures to follow in an emergency that make sure sufficient and suitable people are deployed to cover both the emergency and the routine work of the service.