Unique Care Network Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This announced inspection was undertaken on 18 and 21 January 2019. We informed the provider 24 hours in advance of our visit that we would be inspecting. This was to ensure there was somebody at the location to facilitate our inspection. The inspection team consisted of one inspector 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 service.

Unique Care Network Limited is registered to provide the regulated activity of personal care. This service is a domiciliary care agency. It provides personal care to people living in their own houses in the community. It provides a service to older adults and younger adults. People had needs that related to old age and could include dementia, health conditions, and/or a physical disability. There were 45 people using this service at the time of our inspection.

At the last inspection in March 2017, we judged the service as requires improvement in all five key questions of safe, effective, caring, responsive and well-led and we rated the service requires improvement overall. We also imposed requirement notices for three breaches of regulations because the provider's governance system of checks and audits continued to require further improvement. In addition, the provider had not adhered to safe recruitment procedures. We issued a fixed penalty notice because the provider failed to display their last rating of May 2016 on their website.

The provider was also the registered manager and they were present during our inspection. 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.

At this inspection in January 2019 we found the provider's system of checks and audits remained ineffective. Despite previous inspections identifying shortfalls in governance systems, we found that insufficient progress or improvement had been made to the systems and processes to audit and monitor the quality of care provided and to meet the Regulations. We also identified additional concerns and breaches of regulations. As a result, the service has been rated as inadequate.

We are considering what further action to take.

As we have rated the service as inadequate, the service will be placed in 'special measures'. Services in special measures will be kept under review and, if we have not already taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe, so that there is still a rating of inadequate for any key question or overall, we will act in line with our enforcement

procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

People were not consistently protected from potential harm due to the provider failing to recognise, report and notify the appropriate safeguarding authorities of potential safeguarding concerns. Risks to people's health and safety were not sufficiently identified and risk management plans were not consistently in place. Incidents had not been analysed to identify trends to help prevent the risk of similar occurrences in future. Systems were in place to ensure staff were suitable to work with people in their own homes. There were not enough staff deployed to ensure people received the support they needed at the agreed times. This had impacted on people's well-being and quality of life. People said not all staff followed infection control or hygiene procedures when in their home.

Staff had not consistently had support or competency checks to monitor their practice and ensure they worked to the required standards. People told us that staff sought their permission before providing care and support. However, we identified that the registered provider had not consistently understood their obligations under the Mental Capacity Act (2005). People said staff supported them with their meals and drinks but not always at the right times. There had been a delay in recognising and referring concerns regarding a persons deteriorating health.

People told us that staff who regularly supported them were kind, polite and respectful. Some staff were described as less respectful and people felt rushed. People did not feel listened to and described being distressed by the experiences of missed calls and difficulty in building relations with unfamiliar staff. Language barriers had affected people's ability to communicate with some staff. People told us they made decisions about how they wanted their care provided but staffing issues meant their preferences were at times not known or followed.

People did not feel their care and support was consistently responsive to their needs. Call times had impacted on people's choices and routines which were not always met in the way they preferred. People's support plans were not up to date to provide staff with sufficient guidance on how to meet their needs which meant they did not always receive personalised care. People's complaints had not always been listened or responded to or used to improve people's care experiences.

People and their relatives were not satisfied with the service they received or the way it was managed. The systems in place to assure the safety, quality and consistency of the service were not effective. Checks and audits had not identified areas for improvement. The provider had not taken timely or sufficient action to improve aspects of the service. There was a lack of notifications to CQC to share risk within the service.

You can see what action we told the provider to take at the back of the full version of the 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.

Risks to people's health and safety were not consistently identified or managed which placed them at risk of harm.

The provider had not ensured there were sufficient staff deployed so that people had their care calls at times they needed. This had impacted on people's health and caused distress. Staff vacancies were not covered and existing staff were stretched in their capacity to cover calls.

People told us they did not always feel safe because the service was unreliable and staff did not always support them safely.

Some people were supported with their medicines. Not all staff followed procedures to reduce risks of infection to people.

Lessons had not been learned when things went wrong and the provider had not always acted to reduce the likelihood of incidents reoccurring.

Improvements had been made to the provider's recruitment processes.

Is the service effective?

Requires Improvement

The service was not effective.

People were not consistently supported by staff who had the skills or support and understood how to meet their needs effectively.

People's consent to care was sought however, improvements were required to ensure their rights were protected.

Some people's meals had been affected by call times. Plans did not always identify people's nutritional needs. There had been some delay in referring people to health professionals when required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not feel listened to and described being distressed by the experiences of missed calls and lack of management action in this area.

Some people found it difficult to build a report with different staff undertaking care calls.

Some people described language barriers affected their care. They described a lack of respect from some staff.

People did not feel involved in decisions about their care.

People were complimentary about their regular staff and described them as caring.

Is the service responsive?

Requires Improvement

The service was not responsive.

People did not receive consistent support that met with their needs
and preferences. People did not receive support at the times they needed in response to their needs.

People's support plans were not up to date or reflective of their needs.

People were not confident that their complaints had been listened to and had not always received a response. The provider had not ensured that people's complaints were used to drive improvements.

Is the service well-led?

Inadequate

The service was not well-led.

The provider did not have sufficient oversight of the quality of care and support that people received.

The provider had previous enforcement action and a history of non-compliance in relation to quality monitoring.

Audits were not robust to pick up issues found within the service. There were widespread and significant shortfalls in service leadership and delivery.

There was a lack of notifications to CQC to share risk within the

service.

People's feedback on their experiences did not lead to improvements.

There was a reliance on external agencies to identify shortfalls and where advice was given this had not been followed to make improvements.

Unique Care Network Limited

Detailed findings

Background to this inspection

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

The inspection was on the 18 and 21 January 2019 and was announced. We gave the service 48 hours' notice of the inspection visit because we wanted to ensure there was somebody at the location to facilitate our inspection. The Inspection team consisted of one inspector 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 service.

We visited the office location on 18 and 21 January 2019 and spoke with the provider who is also the registered manager. We also spoke with the deputy manager and eight staff. We spoke with the providers training consultant. Our Expert by Experience conducted telephone calls to twelve people; six people who used the service and six relatives on 18 January 2019.

We sought and reviewed information from the local authority commissioners. Commissioners are people who purchase care packages and who help monitor the quality and safety of the service. We viewed the commissioners telephone surveys conducted with people in January 2019 and this information was used to plan and inform our inspection. We looked at information we already held about the service such as safeguarding and statutory notifications.

We reviewed five people's support plans and daily records to see how their care and treatment was planned and delivered. We looked at how medicines were managed by checking the Medicine Administration Record [MAR] charts for five people and associated audits. We reviewed the staff training records, five staff call schedules, two staff recruitment files, three staff supervision records, the diary,

complaints records, five visit records conducted by the family liaison officer and the provider's own audits.

Inadequate

Is the service safe?

Our findings

At our last inspection in March 2017, we rated the registered provider requires improvement in this key question. The provider had not recruited some staff in a safe way and people's medicines were not consistently managed safely. The provider was in breach of regulations related to staff recruitment and medicine management. At this inspection some improvements in these areas had been made. However, we found significant concerns about managing risks to people's safety and staffing levels which meant people were not safe. The rating is inadequate.

We found risks to people's safety were not always assessed and managed safely. For example, a person's care plan stated the person had specific equipment to support a health condition. There was no instruction in the care plan as to how staff should use this equipment. The person's relative told us they were regularly having to show new staff how to use it. The provider had not assessed this need or carried out any competency checks on staff to ensure they knew how to use this equipment correctly. Another person required thickener in their drinks to prevent them from choking. Whilst staff we spoke with knew how to use the thickener, there was no information in the care plan to ensure this was done safely and consistently by all staff attending calls. Another example was for a person who required the use of heel protectors to support their fragile skin. We saw in the daily diary that a health professional visiting the person in their own home, had reported to the provider that staff had not put the heel protectors on the previous night. We found this incident had not been reviewed or followed up by the provider. There was no risk assessment in place to guide staff as to when these should be used. This could have placed the person at risk of harm. Another person had complained staff were not correctly supporting them with a compression sock. There was insufficient detail in their care plan which had not been updated following the complaint. The lack of clear up to date risk assessments exposed people to the risk of harm.

The failure to ensure risks relating to the safety and welfare of people using the service are assessed and managed was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The local authority who commission care packages from the service told us they had suspended the commissioning of further care packages. This related to late and missed calls and people experiencing poor care outcomes. People and their relatives told us they were happy with the regular staff who they knew and trusted. Some people told us that they did not always feel safe because they had experienced missed calls, late calls or staff not staying for the full duration of the call and rushing them. There had been an impact for people as they had to wait for assistance. One person told us, "It is fine through the week but at weekends it is hopeless especially on Sundays. I never know who is coming. Sometimes I don't get my dinner until 2.30 p.m. and sometimes they don't turn up at all." Another person said, "At weekends they are sometimes late. I never know who is coming. I had to phone up one day when no one came. I get panicky if no one turns up". A relative said, "At the weekends the carers are random and they are unreliable on timing. There is no consistency. We don't feel confident that someone will come at night. It can get frustrating."

Staff told us their calls were in close proximity which enabled them to arrive on time and complete the full

duration of the call. We reviewed five staff call schedules and found these were planned with no travel time between calls. This meant calls frequently overlapped. The provider's systems for monitoring calls were not fully effective as these did not identify the duration of calls, that calls overlapped or that there was no travel time between calls. They had no contingency to cover staff absence; one staff had completed 65 calls working a full seven-day week. The provider told us they had particular difficulties in covering calls in a specific area and at weekends and were recruiting an additional full-time staff member to cover calls. However, this still meant people could not be assured they would receive their calls at the agreed times. We discussed our concerns with the provider who told us they would recruit agency staff in the interim and review call schedules to include travel time. The provider advised they had a plan to monitor all calls electronically by the end of the month via a dedicated office call handler. We saw evidence of telephone monitoring and visits by the Family Liaison Officer in order to monitor people's experiences.

Some people said at times they did not always feel safe. One person said, "One time when they were turning me over in the bed they pulled me too much and I nearly ended up on the floor". Another person told us, "One carer went to fetch water and left me propped up on the bed. The other one got the book and sat on the floor. I was sitting on the bed and could easily have fallen off. She should have been looking after me". Another example was information shared with us from the local authority confirmed that a person had received poor care from the service. This related to medical advice that had not been followed by staff and inappropriate care had been given. The provider had not conducted an investigation or sent a referral to safeguarding to ensure the person was protected from further risk. This incident showed that the provider lacked knowledge around safeguarding people and escalating concerns to the appropriate agencies. The provider informed us that since this incident, they had provided additional training for staff on pressure care, and further advice from Tissue Viability so that staff understand the importance of recognising deterioration and following medical advice. However, lessons had not been learned when things went wrong and the provider had not always acted to reduce the likelihood of incidents reoccurring. For example, ensuring risks assessments were updated with risks.

Staff we spoke with told us that they had received safeguarding training and how to report if they had any concerns. They said they would inform the management team who would report to the local authority safeguarding team.

The provider had improved their recruitment checks and was no longer in breach of this regulation. Staff we spoke with told us that checks were undertaken before they started work. Records showed that a disclosure and barring service (DBS) security check, and identity, health status and references were obtained.

Most people managed their own medicines. Those that needed help to do so had no concerns about how the staff assisted them. We saw the provider had systems in place to manage and check that medicine administration record (MAR) were signed. We saw that where topical creams needed to be applied, body maps and records were maintained. Staff told us and we saw from records that they had been trained and assessed as competent to manage people's medicines safely.

People were not always protected from the risk of infection. People told us the staff wore gloves and aprons whilst assisting them. However, some people commented that some staff did not practice safe hygiene. One person said, "One of the lunchtime staff keeps her coat on (even when helping me to the toilet) over her uniform during her visit". Another person said, "Some [staff] don't tidy up in the kitchen when they leave". We also had concerns shared with us prior to the inspection which identified staff do not consistently apply good infection control practices. Staff had received training in infection control and food hygiene and explained good practice to us. However, this was not consistent across the staff team. We saw that staff practices were being addressed via formal supervision sessions with staff who did not comply with policy

and procedures. Additional training had been scheduled for all staff in infection control to reinforce learning and skills. The provider was working to an action plan with the local authority and we saw they had recruited a Family Liaison Officer who had made several visits to people to follow up on their concerns.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in March 2017, we rated the registered provider requires improvement in this key question. Some people and their relatives felt that the staff did not always have the skills or training needed to meet their needs and people did not have confidence in the staff. At this inspection the rating remains unchanged.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People told us that staff sought their consent prior to entering their home or assisting them. One person said, "The staff always ask me before doing anything". Another person said, "They involve me in decisions about my care; what I want to eat, if I want a bath or not, they always ask".

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this where personal care is being provided must be made to the Court of Protection. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider told us no one was subject to a Court of Protection. We found that a relative had given consent on their relations behalf for the use of bed-rails. In another instance a relative had signed a person's consent to care. In both instances there was no MCA assessments or best interest's decision recorded to show the provider had considered people's capacity and assured themselves that the relative had the legal authority to consent to the use of bedrails. Although staff demonstrated awareness of seeking consent they did not fully understand or have training in MCA and DoLs to support people's rights. The provider told us training was being developed to support staff.

The failure to ensure care and treatment is provided with the consent of the relevant people is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we saw staff were completing relevant training. Staff told us they had an induction in which they completed relevant training and had the opportunity to shadow experienced staff. However, people said that not all staff were trained or competent in meeting their needs. A person said, "Anybody can come at any time with very little training". Another person said, "One carer just stood there and I had to instruct her how to wash me. I wonder how much training they have".

We found the provider did not consistently check the competencies of staff to ensure they understood and worked effectively to meet people's needs. For example, a person said, "The carer she asked me how to make a cup of coffee, also I am diabetic and one carer put sugar in my drink, another put salt on my shredded wheat". In addition, people told us they had experienced language barriers which meant at times they could not communicate with their carer. A person said, "Some [carers], can't speak English and half of the time I can't understand what they say and they don't understand what I say". The provider told us they

had begun to match people and staff who shared the same language. They were also improving their induction and training. They had engaged the services of an external trainer who had appraised staff skills and had produced development plans designed around the learning needs of each staff member. We saw a schedule of staff training was in place to address gaps.

Staff told us that they felt supported and could contact the managers for advice when needed. However, staff had not all received regular formal supervision to ensure they all worked consistently to the required standards. People's feedback about staff competency had not always been followed up. Whilst spot checks on staff performance took place these had not identified the lack of skills people had described to ensure all staff worked to the expected standards needed.

People told us that they were involved in an assessment of their needs before they started to use the service. We saw that people's medical history, mobility, medication and preferences for time of care calls were assessed. This information was used to develop people's care plans and enable the provider to decide if staff had the skills to meet people's needs effectively. However, this assessment had not ensured people were matched with staff who shared the same language. We discussed this with the provider who told us they had agreed to refer carers to training in 'English For Speakers of Other Languages', [ESOL].

Some people required the support of staff to assist with their meals and drinks. Most people confirmed that staff prepared their meals and drinks in a way they wanted. People told us staff always ensured they left food and drink within easy reach of them. A person told us, "I don't have any problem with regular staff; they will make me what I want and do a good job, some of the newer staff are not so good". A relative told us that they worried if staff would be on time to assist their family member with meals and drinks. Some people commented staff did not arrive at the time for their meals and they had to wait. Staff we spoke with understood where people needed their meals prepared in a particular way to be able to eat safely. They were also aware of monitoring people to ensure they ate and drank enough and how to report any concerns about people's intake to ensure their health. Where people required a specific diet such as diabetic, their support plan did not include sufficient information to guide staff to prepare their meals safely and there was evidence that at times inappropriate foods had been given.

People said staff supported them with their health needs and to contact healthcare professionals when required. Staff we spoke with described situations where they had recognised changes in people's health and called emergency services. Staff said if they had any concerns about people's health they would seek advice from the office. However, prior to our inspection we were informed about an incident where staff had not recognised changes in a person's skin integrity or taken timely action to refer the person to healthcare services. This demonstrated staff were not always aware of their responsibility to monitor people's health needs and consistently act on issues identified.

The provider told us they had since provided additional training to staff. We saw staff were recording positional changes to provide pressure relief and body maps were in use to guide staff as to where any creams should be applied. The person's visits had been organised around their pressure care needs. However, the care plan had not been updated with the information related to the person's pressure sore management. This means staff not familiar with the person's needs would not have up to date information to manage their healthcare needs consistently. A second person had a medical condition; diabetes, but their care plan had no information as to how diabetes affects the person or any possible complications staff should look for to support them with their healthcare needs.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in March 2017, we rated the the registered provider requires improvement in this key question. This was because the provider had not promoted a caring service; people had experienced distress due to missed calls. At this inspection the rating remains unchanged.

People told us they had been distressed and felt rushed with staff not arriving at the agreed times or staying the full duration. A person told us, "They are gone in 20 minutes but they should be there for 30 minutes. Certain ones are trying to rush me and don't want to give me a proper wash". Another person said, "Some of the carers do the job well but others are very poor." People told us that they lacked confidence in staff, particularly where it was not their regular staff. A person said, "At the weekends the carers are random and they are unreliable on timing. There is no consistency. We don't feel confident that someone will come at night. It can get frustrating".

Where people received care and support from a consistent staff member they had formed positive relationships and had confidence in them. People also said they could communicate with their staff member and that staff knew them well and they were happy with the caring approach of the regular staff. A person said, "I am very pleased with them overall. They have a chat with me."Another person said, "They are friendly, they do have time to talk to you." A relative told us, "[Names] regular carer always goes the extra mile".

The provider had not made progress on providing people with a consistently caring service where they had the staff known to them supporting them. There had also been a lack of consideration in matching people with staff who could communicate with them which had caused some distress and frustration.

Most people told us staff treated them with respect and protected their dignity. People said their regular staff considered their comfort and privacy when providing personal care. However, some people said that staff were not always respectful when providing personal care. A relative told us, "The non-regular carers don't give personal care properly; they are not thorough with washing and they don't cream her legs. They skip the jobs". Several people commented that some staff lacked respect because they spoke amongst themselves in a different language. A person said, "They talk to each other or are on the phone. They ignore you". Another person said "They talk a lot to each other in their own language between themselves. I don't like that. They are on the phone a lot. They make phone calls while looking after you".

People said they maintained their own independence and staff supported them when they needed this. They confirmed that aspects of their care and daily lives continued to be managed by them. A person said, "I do some things myself but if I have an off day the staff will ask me and I'm okay with them doing it". Some people did not feel involved in decisions about their care because they did not have a regular staff member support them in their preferred way.

The registered provider and staff were aware of the need to maintain confidentiality in relation to people's personal information. We saw personal files were stored securely in the office.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in March 2017, we rated the registered provider requires improvement in this key question. This was because complaints had not been documented or used to improve the quality of care provided. At this inspection the rating remains unchanged.

People and relatives told us they were provided with information on how to make a complaint. However, they said they did not have full confidence their complaints would be resolved. People said they often could not get through to the office to share their concerns or when they did they had no feedback. One person told us, "I have made numerous complaints about the weekend carers but they are always ignored".

Records showed there had been a number of complaints regarding missed calls, late calls and the standards of care provided. The provider acknowledged there had been an increase in complaints with common themes. They had employed a family liaison officer who we saw had visited people to follow up on their concerns. We saw from records that concerns were being investigated retrospectively. We saw action was taken to improve the service people received. For example, where a staff member had not arrived at a person's house, we saw an apology had been given and action taken with the staff member which included spot checks on them. In another case late calls had affected a person who needed to eat before their insulin injection. An apology was provided and staff were informed to keep to the call times to avoid a repeat. We found that some of the more recent complaints were being responded to with clear actions in place to monitor individual staff performances and provide an apology and assurance to the person. However, the systems in place to manage and respond to any complaints or any concerns raised had not been consistent and as such people's experiences had not been improved. The provider told us issues from complaints were discussed with individual staff members, and raised at staff meetings to reinforce good practice. Staff told us they were updated with changes to improve their practice. Most staff felt that the increase in complaints related to call times and staff performance. They felt that new staff at that time were not performing to the expected standards and staff vacancies had further generated difficulties. Staff told us that with the recruitment, new training and improved support they were more hopeful people would receive a better service.

People and their relatives confirmed that at the start of using the service they were involved in discussing their care and support needs. We saw people's care plans included people's likes, dislikes, medical history, care visit times and how people like to be supported. People's communication needs were captured in their care plans and staff were able to say how these were met. For example, some staff members described how they supported people using their preferred language. From April 2016 all organisations that provide adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand, so that they can communicate effectively. Care plans we reviewed contained some information about how to support people, for example, ensuring they were wearing their glasses or hearing aids or speaking with them in a clear way they could understand. Staff told us they and family members often read or interpreted information for people whose first language was not English. The provider had not provided people with information about the service or a care plan in a format which met

their needs, such as in large print, pictorial or other languages, although they said this could be provided on request.

People's cultural and religious needs were understood by staff. For example, staff described supporting people by respecting prayer times, removing shoes on entering the house or supporting people to dress in a manner suited to their culture or religion. Staff had undertaken some training in relation to equality and diversity and displayed a good understanding of not discriminating against people. The providers assessment process did not include exploring the needs of people from the Lesbian, Gay, Bi-sexual and Transgender community (LGTB), to ensure people received personalised care.

People said their care plans had been reviewed with them but not on a regular basis. Some people said they were not always made aware of changes to their care plans. A relative said "There are mistakes in (name) plan but I am not worried about that"." Another relative said, "Their care plan is reviewed from time to time". We saw from care plans that these were not updated with changes to people's care and therefore did not provide accurate information as to how people should be supported. We also saw some staff had not supported people in the way they had needed, such as arriving on time, following personal care routines or providing the right food. Some people said that when a new carer arrived, they did not read the care plan to find out about the tasks or people's preferences but relied on the person or relative to explain to them what they wanted. A person said, "They don't look at the care plan". Another person said, "One carer just stood there and I had to instruct her how to wash me. If I didn't have my senses they wouldn't know what to do. You should look through the care plan to see what to do and they don't". This meant people did not always receive personalised care in response to their needs.

Some people said their regular carers understood and responded to their needs. One person told us, " I lost the rubber from the end of my walking frame. I told the carer when she came. It made my frame wobbly and I was frightened of falling. She brought me another two frames to try". Most people said their regular staff followed the care plan and were happy to assist them in different ways; doing something extra such as tidying up, hanging the washing out or cooking something for them. Other people described how staff were mindful of placing the phone and TV remote within their reach and making sure they had their pendant alarm on for emergencies. Staff we spoke with knew of people's changing needs and confirmed they were informed of these but that the care plan was not always up to date with changes. Some people required two staff to assist them but at times this was inconsistent. Staff told us and there had been difficulties in both staff arriving on time. However, they confirmed they had been instructed to inform the office and wait for a second staff member to ensure people had safe support.

Inadequate

Is the service well-led?

Our findings

At our last inspection in March 2017, we rated the registered provider requires improvement in this key question. We found that the systems and processes to assess, monitor and improve the quality and safety of the service were not always effective. The provider has been rated requires improvement in this key question since June 2015 and has twice been in breach of regulations related to the quality of monitoring of the service. At this inspection, we found little improvement in their systems and overview and identified additional concerns about people at risk of poor and unsafe care. We have rated this key question, inadequate.

People and their relatives consistently told us the service was not well-led. People had poor care experiences and did not have confidence in the provider. They described difficulties in getting responses to their concerns and an unreliable service. People did however comment that their regular staff were kind and understood their needs, but they felt staff were worked too hard which made them rush.

Before our inspection, Commissioners of the service had shared concerns with the provider about their staffing arrangements and the standard of care people received. They had suspended the service from offering more packages of care until improvements were made. The provider told us they were working to an action plan with the local authority monitoring this.

At this inspection we found the quality assurance processes continued to be ineffective and did not pick up on the issues identified at inspection. These included concerns with managing risks to people's health and well-being, staff deployment, staff skills and poor record keeping.

We found that although an action plan was in place to schedule call times and include travel time, this had not been achieved. For example, we saw call schedules were planned with no travel time between calls and times of calls overlapped. The provider had not taken action to include travel time or review call schedules to provide sufficient time for staff to complete the call duration. The provider did not have an effective system for monitoring the duration of calls. Our feedback from people identified a number of complaints related to missed and late calls and the impact of this on their daily lives. The local authority had also surveyed people and found they had experienced late and missed calls. Whilst the provider was aware of staff shortages they had not taken steps to cover staff vacancies to reduce risks or minimise the impact on people who used the service. The providers systems did not identify that quality and or safety of people was being compromised and that existing staff were being stretched.

The provider did not carry out regular audits on people's care plans and risk assessments to ensure these provided up-to-date and accurate information for staff about service users' conditions and how they should be supported. Risks to people's safety were not appropriately assessed and monitored. For example, care plans were not in place related to medical conditions such as diabetes, the use of thickener in drinks, pressure care management and using specific equipment to support people. The lack of up to date plans and risk assessments placed people at risk of not receiving consistent and appropriate care and risks were not effectively reduced. The oversight and governance systems to monitor the quality and safety of care had

failed to identify records were incomplete and were unreliable to ensure staff had accurate information and guidance to provide safe and effective care.

We found that people's and professionals feedback about the service was not always acted on to drive improvements. For example, we saw three incidents where complaints and concerns had been shared with the provider about supporting people's fragile skin. These had come from different sources; two from health care professionals where the provider had not ensured that staff followed medical advice given by healthcare professionals and in one instance inappropriate care had been given to a person. In another instance advice had not been followed to protect a person's skin placing them at risk of harm. There was no record to show lessons had been learned when things went wrong or that the provider acted to make improvements to people's care such as updating care plans to show the support the people needed to reduce the likelihood of it happening again.

People's feedback was sought via surveys; the most recent survey in December 2018. This identified people were unhappy with the standards of personal care, call times and staff skills. The results of the surveys had not been analysed or acted upon. The provider told us they had recruited a family liaison officer who was meeting with people to address concerns retrospectively. We saw reports that confirmed this.

The providers spot checks on staff performance were not effective in identifying if staff worked to the required standards or had the right knowledge and skills to undertake their role. This included assessing staff competency to carry out specific tasks, such as personal care skills, hygiene and infection control, basic cooking competencies and any language barriers. The provider had, engaged an external training consultant. We saw the consultant had assessed staff competency to carry out specific tasks, such as moving and handling. They were developing a training plan based on each staff member's needs. This was seen to be in the early stages. However, the provider had not looked at ways to improve the quality to people until this was identified by external agencies and not through their own audits.

The lack of oversight of staff practices and record keeping combined with the issues about staff deployment meant people did not consistently receive safe care from regular staff who knew their needs and had the skills to respond to their needs.

Systems and processes had not been established or operated effectively to assess, monitor and mitigate the risks to people's health, safety and welfare. This constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

We found that the registered manager, [who is the provider], and their deputy did not have a clear understanding of how they were to meet the regulations to ensure people received a safe, effective, caring and responsive service. There was a reliance on reacting to external prompts but also examples of where these had not been followed to make improvements. The provider told us they were committed to making improvements, and whilst they had recently invested in additional resources their history of compliance did not give assurance this could be sustained. This meant that people were at risk of not receiving consistent and reliable care and support that met their needs.

Roles and responsibilities were not clear. The provider was supported by a deputy manager. However, there were no records available of management meetings to indicate shortfalls were being discussed and improvements planned. For example, the provider had agreed with the local authority to maintain a record of late calls and report on these at management meetings. We asked the registered manager and deputy for minutes of these meetings but were told these were not yet up and running; one had taken place to draft an action plan. We asked who was responsible for updating care plans, risk assessments, and emerging risks

but this was not clearly delegated and had not been done. This meant the provider had not demonstrated how they were addressing shortfalls and who was responsible for managing the changes.

The last CQC inspection ratings were on display as required. The provider had complied with a previous breach related to failure to display their inspection ratings. However, the provider did not always demonstrate understanding of their responsibilities to the Commission. For example, it was identified that a notification had not been made to Safeguarding or CQC as appropriate in relation to a person suffering a grade four pressure sore. The service was not always open or transparent. For example, information had not always been given to people about their complaints or the issues with call times or who was turning up to care for them.

The registered provider told us they shared appropriate information with other health professionals for the benefit of people who use the service. However, prior to our inspection we were informed they had not taken timely action to refer a person to healthcare services.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent to care and support was not always sought in line with legislation and guidance.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from harm due to inadequate risk management processes within the service. Regulation 12 (2) (a) (h)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective system in place to regularly assess and monitor the quality of service that people received. The provider did not monitor and mitigate the risks relating to the health, safety and welfare of people.