Essential Care Limited

Expertise Homecare (Maidstone)

Inspection report

Wiltshire House
Tovil Green
Maidstone
Kent
ME15 6RJ

Tel: 01622427886
Website: www.maidstone.expertisehomecare.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out between 22 and 23 October 2018 and was unannounced.

Expertise Maidstone is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults. Not everyone using Expertise Maidstone receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. There were 28 people receiving a service at the time of our inspection.

A registered manager was employed but they were not working at the service at the time of 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.

This was the first inspection of this service since it was registered in May 2018. We inspected the service in response to concerning information we received from the provider about the risks to people, the recruitment of staff and the governance and leadership of the service. We found that the provider's concerns were correct. During the inspection the provider decided to stop providing the service the following day as they were unable to ensure people's safety. They worked with the local authority commissioning staff to support people to receive care from other providers.

The provider did not have the required oversight of the service. Robust checks on the service people received had not been completed to make sure people always received a good standard of care. People, their relatives and staff had been asked for their feedback, however any concerns had not been acted on and used to improve the service. Accidents and incidents had not been analysed and action had not been taken to stop them happening again.

There were not enough staff available to give people the support they needed, when they needed it. Staff often arrived late and told us they rushed between visits. Some visits had been cancelled and people's relatives had been left to provide their care. The provider did not have sufficient staff available the day after our inspection to provide people's care. They stopped providing the service at this time as they were not able to keep people safe.

Staff had not been recruited safely. Checks on the character of staff including Disclosure and Barring Service (DBS) criminal records checks had not been completed. Staff were not supported to meet people's needs and some had not completed the training they needed to fulfil their role. Checks had not been completed to make sure training had been effective and staff were competent. Staff were unclear about their roles and responsibilities.

Staff felt supported by the office staff but were demotivated. There was not a shared vision of a good quality service. An experienced member of staff was not available to provide the support and guidance staff needed, including outside of office hours. Records in respect of each person were not accurate and complete and were not always kept secure.

Staff had not considered people's equality, diversity and human rights when planning their care and there was not a person-centred culture at the service. People did not receive care tailored to them. Effective assessments of people's needs had not been completed and risks had not been identified. No guidance was available to staff about how to keep some people safe and provide each person's care in the way they preferred. Guidance about other people was not specific and detailed. People had not been asked about their care preferences at the end of their life.

Staff knew the signs of abuse and raised any concerns they had with the registered manager. However, these concerns had not been shared with the local authority safeguarding team so they could take action to keep people safe. Staff including the assistant manager did not know they could whistle blow about concerns they had. Staff were not supported to followed safe practices to prevent infections and there were no stocks of disposable gloves in the correct size.

People and their representatives told us they were confident to raise any concerns they had with office staff. However, an effective system to receive, investigate and respond to complaints was not in operation and some complaints had not been acted on.

People were supported to have maximum choice and control of their lives and the policies and systems were in operation to prevent this. Staff supported them in the least restrictive way possible. Everyone was able to make decisions for themselves and staff supported them to do this.

Services that provide health and social care to people are required to inform the CQC, of important events that happen in the service like a serious injury. This is so we can check that appropriate action had been taken. We had not been notified of all significant events at the service.

People told us the staff were kind, caring and friendly. People were supported to eat and drink enough.

People's medicines were not always managed safely, staff had not received the training to understand how to administer some medicines, and this impacted on people and their wellbeing.

Staff recognised when people were unwell but did not take the appropriate action and did not support family members to access appropriate support.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept

under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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 had not been identified and mitigated.

People were not protected from the risks of unsafe medicines management.

Staff had not kept people safe when they were at risk of abuse or discrimination.

Action had not been taken to stop accidents and incidents happening again.

There were not enough staff who knew people well, to provide the care people needed.

Staff were not supported to prevented and controlled infection.

Checks were not completed on staff to make sure they were honest, trustworthy and reliable before they worked alone with people.

Is the service effective?

Inadequate

The service was not effective.

People's needs were not assessed with them.

Staff were not supported and did not have the skills they required to provide the care and treatment people needed.

People were not supported to access healthcare professionals when needed.

People were supported to eat and drink enough to help keep them as healthy as possible.

Staff followed the principles of the Mental Capacity Act (2005).

Is the service caring?

Inadequate

The service was not caring.

People were not always treated with compassion, dignity and respect and did not have control over their care.

Staff did not know about people's cultural needs, sexual orientation or gender identity.

Is the service responsive?

Inadequate

The service was not responsive.

People had not planned their care with staff. Each person did not have a care plan that was tailored to meet their individual needs.

A complaints system was not in operation.

People had not been asked about their preferences at the end of their life.

Is the service well-led?

Inadequate

The service was not well-led.

Checks had not been completed on the quality of the service. Effective action had not been taken to remedy any shortfalls.

People, their relatives and staff had not been asked for their views and experiences of the service.

There was not an open culture at the service.

Staff were demotivated and not led by the provider and registered manager. They were not clear about their roles and responsibilities.

Expertise Homecare (Maidstone)

Detailed findings

Background to this inspection

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

This inspection took place on 22 and 23 October 2018 and was unannounced.

Before the inspection we reviewed notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law. We did not ask the provider to complete a Provider Information Return because we inspected the service at short notice. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we had received from the provider about shortfalls they had found at the service and the action they were taking to address them. We also spoke with the local authority commissioner.

The inspection site visit activity started on 22 October and ended on 23 October. It included meeting people and their loved ones and talking about their experiences. We visited the office location to see the provider and office staff; and to review care records and policies and procedures.

The inspection team consisted of two inspectors.

We looked at five people's care and support records, associated risk assessments and medicine records. We looked at management records including four staff recruitment, training and support records and staff meeting minutes. We observed people spending time with staff in their own homes and spoke to them about their experience of Expertise Maidstone. We spoke with the provider, five staff, and 5 people who use the service and their relatives.

Inadequate

Is the service safe?

Our findings

We inspected Expertise Homecare Maidstone following concerns received about people's safety. We found that people were not safe.

People were not protected from the risk of abuse. Staff told us they had received training and were able to describe what signs and symptoms of abuse. Staff also stated that they were confident that office staff would act appropriately if they raised concerns. However, we found that this had not happened. Several staff told us about concerns they had raised with the registered manager about one person. The staff member who was deputising for the registered manager told us they had the same concerns and had informed the registered manager. They did not know what action had been taken and no records had been maintained. We asked them why they had not raise concerns with the local safeguarding authority and they told us, "If I'd known I could do that, I would have done something before". We asked the provider to raise a safeguarding alert to the local safeguarding authority during our inspection.

The provider and registered manager had failed to protect service users from abuse and improper treatment. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Potential risks to people's health, safety and welfare had not been consistently assessed. Detailed guidance was not available to staff about how to manage risks. No risk assessments had been completed for five people to identify any risks. Potential risks had not been consistently assessed for other people. Six people had detailed risk assessments from their previous care provider but these had not been reviewed to ensure they remained relevant.

Some people had complex health and care needs, such as supra-pubic catheters and stomas, which supported them with their continence needs. Staff supporting people with these needs had not received training or had their competency to support people assessed.

Guidance had not been given to staff about how to support people to move around safely and reduce their risk of falling. One person's mobility risk assessment stated the person should use a standing hoist. They had been reviewed by the occupational therapist (OT) in June and the OT had recommended the person did not stand. Incidents of staff supporting the person to stand were reported to the management team by the person's relatives in September. No action had been taken in response to these concerns. The risk assessment had not been amended and the person continued to be at risk. Other people used equipment such as a transfer board to move between furniture or equipment. Guidance had not been given to staff about how to position the board, how to support the person and any other equipment they used. This increased people's risk of falling.

Action was not taken following accidents or incidents to keep people safe. During one call, a person fell and hit their head. Staff checked the person was ok and then left. The person did not receive any more visits during the day. There was no record that any further action being taken to check the person was safe and

well or what action had been taken to reduce the risk of them falling again.

Incident records showed staff had noticed that one people had not taken their medicine correctly. There was no record of any action taken to review the person's needs. Other incidents recorded that people had shown signs of being unwell such as not being able to stand as well as usual. No action had been taken to ensure that people were safe following these incidents.

People were not consistently protected from the risk of infection. Staff did not have a full understanding of how to prevent the spread of infection. Guidance had not been given to staff about how to recognise the signs of infection, particularly when people had complex needs and what action to take if people became unwell. When people had complex needs, guidance was not available to staff about how they should support people to reduce the risk of infection. During the inspection, staff came into the office to collect disposable gloves. However, there were no stocks of medium gloves available, the size that most staff wore. Office staff believed that the registered manager had ordered gloves and were awaiting their delivery. The provider confirmed the gloves had been ordered and they were not aware that stocks had run about. There was a risk that gloves would split or come off while staff were supporting people. One staff member had refused to wear disposable aprons in September 2018. A plan was agreed that they would wear them for one week and would them discuss this with their supervisor. No further action was taken in relation to this and office staff were not able to confirm if the staff member wore disposable aprons to reduce the risk of them spreading infection from one person to another.

The provider and registered manager had failed to assess risks to service users' health and safety and mitigate any risks. The provider and registered manager had failed to assess the risk of and prevent the spread of infections. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected by safe staff recruitment practices because the provider's recruitment policy had not been followed. The required checks had not been completed to make sure staff were of good character and had the skills and experience needed to fulfil their role. Disclosure and Barring Service (DBS) criminal records checks had not been completed for 16 of the 27 staff who provided people's care. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Two staff had declared they had a caution or conviction. No further information had been obtained about these and the risks to people had not been assessed and mitigated.

Information about some staff's employment history, experience and training had not been obtained before they were employed and began providing people's care. One staff member worked alone with a person with complex needs. Information about their skills, knowledge and experience had not been obtained and references had not been requested. We asked office staff what support and supervision arrangements were in place for the staff member. They told us, "We don't really have any communication with them. They just get on with it". We raised concerns about the safety of the person this staff member was supporting during our inspection. The provider stopped the staff member from working and arranged for the necessary checks and training to be completed before they worked with people again.

The provider and registered manager had failed to operate effective recruitment procedures and ensure that persons employed were of good character and had the qualifications, competence, skills and experience necessary for their role. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There were not enough staff to meet people's needs. One staff member told us that on the day following our

inspection there were not enough staff to provide 18 people's care. Some people needed two staff to meet their needs. One staff member had been identified to support nine people but a second staff member had not been identified. No staff had been allocated to meet another nine people needs. Staff call rotas supported this.

Relatives described how they had worked with the staff to agree call time but staff were sometimes late and they were not always informed. One relative told us, that a call was cancelled the weekend before the inspection, and they had cared for their loved one. Office staff told us that call rotas were designed to minimise staff's travel between each call and five minutes had been allowed between each call. However, staff told us, this was not enough time to travel between calls and were always running late. In the evening they finished later than the agreed time. Staff were also required to collect other team members if they did not have a car and drop them at their call before going on to complete their own calls. This had not been considered when calculating the time between calls. A log of calls received by the on-call member of staff showed that on numerous occasions staff had rung to say they would be late. Late calls had not been recorded and analysed to identify the causes and plan how to reduce them.

People and relatives told us that they knew which staff would be coming to support them and they now had regular staff. They told us this was an improvement. A new coordinator had started four weeks before our inspection. It was their role to plan the call allocation and they were endeavouring to provided people with consistent staff. Staff confirmed this and said the calls were now more organised. The staff member who coordinated the calls had resigned and was working their notice. Staff continued to be late and on a few occasions calls had been cancelled. The on-call records showed that on one occasion in October, staff had text the on-call staff member to inform them that they would not be completing their calls. There was no record of the action taken to cover the calls.

Staff did not receive adequate support from a suitably qualified, competent, skilled and experienced staff member outside of office hours. The member of staff who undertook most of the on-call duties did not have any social care qualifications and had not worked in social care before being employed by Expertise Maidstone in July 2018. Another staff member told us they had covered the on call ten days after starting work at the service and was expected to advise staff about people they knew nothing about. Staff had not been given the correct guidance to unsure people were safe by on-call staff. One person had fallen before staff had arrived at their home, staff reported that the person was unable to stand and was screaming in pain. The guidance, which staff followed, was to provide the person's care and then leave the property as a relative was there with the person and to carry on with their rounds. Staff did not know what action to take when someone was displaying pain following a fall and the person was later admitted to hospital with a fracture. The guidance from the on-call staff member meant that the person continued to be in pain and medical treatment was delayed.

The provider and registered manager had failed to deploy sufficient numbers staff to meet people's needs. The provider and registered manager had failed to ensure staff received appropriate support carry out the duties. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported to take their medicines safely. One person had been prescribed a new medicine shortly before our inspection. Staff did not know what the medicine was or how it was to be administered. Staff had not administered the person's medicine the day before our inspection because guidance was not in place regarding its administration. Action had not been taken to obtain the information required, update the person's care records and inform staff of the changes. On another occasion, one person was prescribed pain relief to be given when they required it. The on call record showed that staff had

spoken to office staff about whether to give the medicine, staff were advised to give the medicine but they refused. The person was left in pain and started continuous pain relief the next day.

Staff recorded the support they gave people to take their medicines on the electronic care plan system. The system did not allow staff to sign out of the call, unless it was confirmed that the medicines had been given. We reviewed the electronic record which staff had completed and this was accurate.

The provider and registered manager had not ensured that medicines were properly and safely managed. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People were at risk of not receiving safe and effective care because staff had not received the training they needed to undertake their roles and meet people's individual needs. The provider's induction process had not been completed by all staff and staff's competency to provide care had not been assessed before they worked unsupervised. We looked at the records for a senior carer who supported staff and provided people's care. They had not completed any induction or training and had not held a care position previously. The provider had a process of regular checks on staff performance which included unannounced spot checks at people's homes. These had not taken place for some staff and the provider and office staff did not know how staff were performing their roles.

Staff did not receive regular supervision to enhance their skills and learning. For example, one staff member had received one supervision since their employment in July 2018. This noted that they had been requested to remove their long finger nails as they were a risk of people. We observed that they had very long nails during the inspection and continued to provide people's personal care.

The provider and registered manager had failed to ensure staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out their duties. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care and support people received was not based on a comprehensive assessment of their needs and wishes. Staff met with people and their relatives when necessary, to talk about their needs before they received a service. A basic assessment was completed which summarised people's care needs. However, important information such as the support people needed to meet complex needs and how they liked their support provided had not been obtained. Further assessments of people's needs had not been completed, in line with best practice, such as moving and handling assessments. Assessments had not been reviewed to identify any changes in people's needs. The provider had arranged for staff from another service to reassess everyone using the service. This process had begun shortly before our inspection.

The provider and registered manager had not carried out, with the service users and others, an assessment of their needs and preferences for care. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Technology the provider had put in place to enhance people's care delivery was not effective. The provider had an electronic care planning and recording system designed to ensure office and field staff had access to the latest information about people, their care needs and service delivery. However, this technology was not effective and several staff had not been issued with a tablet computer. Other staff reported that due to poor mobile phone coverage they were often unable to share information such as the care they have received and any changes in their needs. This meant that office staff and staff visiting people at other times did not know about and changes or concerns. Office staff were not competent in using the care records system and were unable to give us some of the information we needed.

Staff supported people to move as much as possible to remain healthy. However, they did not always support people to access the health care they needed.

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

People were able to make decisions about their care and treatment. Staff described how they supported people to make their own decisions where possible. Staff understood their responsibilities to give people the information they needed to make decisions and when people had been assessed as having capacity, respecting their decisions. People's capacity had been assessed when they started using the service and this was recorded in the care plan.

Staff supported people with their meal preparation when required. People were supported to eat snacks and hot meals throughout the day to keep them as healthy as possible.

Inadequate

Is the service caring?

Our findings

The provider and registered manager had not ensured that people were consistently involved in their care and treated with compassion, kindness, dignity and respect. Staff we spoke with told us they would not be happy of a member of their family to receive a service from Expertise Maidstone.

People had not been asked to share information about any protected characteristics they may have under the Equality Act. Staff did not know how people had chosen to live their lives and action had not been taken to reduce or remove any barriers to communication or care. Staff did not understand who was important to people, their life history, cultural background, spiritual beliefs and sexual orientation.

People told us that recently the same staff were supporting them and they were building positive relationships with staff. We observed people being comfortable and relaxed in the company of staff, people smiled and laughed when chatting to staff. When people and relatives spoke about staff it was with affection. One relative told us, "staff are not strangers for long." However, people were not involved in choosing the staff who supported them, including their gender, which is very important to some people. Office staff had not endeavoured to match people with staff based on their personality or shared interests so they could develop friendships. People had not been asked if they liked the staff who supported them or choose if they supported them again.

Staff knew what caused people to become anxious or upset but had not taken action to support them. Staff told us one person did not drink very much because they were anxious about falling when they went to the toilet. Action had not been taken to support the person to seek advice and from health care professionals such as physio or occupational therapists to increase their mobility and reduce the risk of them falling.

Care had not been planned to support people to remain as independent as possible. For example, information was not available to staff about what people were able to do for themselves and what support them needed to complete other tasks. People told us that the staff met their needs and did all the things they wanted them to do.

Information about people was not held securely. Some staff did not have a tablet computer, issued by the provider to view people's records. These staff told us they used their personal mobile phones to access information about people. This information was not protected by encryption. We observed that one staff member kept the password to log into the care records system on a piece of paper with their phone. This increased the risk of people's confidential information being accessed by someone who did not have the person's permission to view it. The provider and office staff did not know which staff had tablet computers issued by the provider and who did not. They also did not know where all the tablet computers the provider had purchased were because a system was not in place to ensure staff handed them back when they left.

People and their relatives told us that the staff were kind and treated people with dignity. One person told us, "We are all part of a team, they are very professional and never make me feel embarrassed." People were referred to by their preferred name and staff followed their wishes when they entered their house such as

removing their shoes. People told us that staff were considerate of their relatives and had supported them when their relative was unwell. Staff had called for medical help for the person's relative and then spent time supporting the person as they were upset. However, this support was not consistently provided to people and their loved ones.

Some people who needed support to share their views about their care were supported by their family, friends, case manager and power of attorney. However, other people were not supported and staff had not referred them to advocacy services when they needed support. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf.

The provider and registered manager had failed to design service users' care with a view to achieving their preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

People had not been fully involved in planning their care with staff so staff could provide their care in the way the preferred. Some people did not have care plans containing detailed and specific information for staff about how to deliver their care. Five people had no care plan at all There was limited information in people's care plans about the support they needed to manage their complex needs. One person required support with all aspects of their daily life. Their care plan was four lines long, it did not include what the person could do for themselves and their preferences. The care plan stated that staff should change dressings, but there was no guidance about how to do this. Other people had previously had medical conditions such as blood clots. Care plans did not give staff guidance on how to support the person to stay healthy and what signs they may see if the condition had reoccurred.

Some people used equipment to help move around their homes, including hoists. Guidance was not included in people's care plans about each piece of equipment and how to use these correctly.

Care plans which were in place had not been regularly reviewed with people or updated as their needs and goals changed. Plans were in place to review everyone's care plan and this process had started. Staff at the service did not have the skills to complete this task and reviews were being completed by staff from another organisation at the request of the provider. Some staff did not have access to information about people because it was not available in people's homes and they did not have a tablet computer with the information stored on it.

Staff were required to record on the tablet computer the care and support people had received each day. This was so other staff, including office staff had access to important information about changes in the person's needs or signs that they may be unwell. Staff told us they were often unable to update the records because there was no internet connection or they did not have a tablet computer.

People had not been offered the opportunity to tell staff about their care preferences at the end of life. There was a risk the people would not get the support the support they wanted in the way their preferred because their preferences, such as any spiritual or cultural preferences had not been discussed. No one using the service was having support at the end of their life. Staff had supported people to stay at home at their end of their life when they preferred and worked with health care professionals including community nurses to support people to be comfortable.

From April 2016 all organisations that provide NHS care or 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. The provider and registered manager had not ensured people were provided with information in ways they understood, such as large print, to support people to tell staff about their needs and wishes and be involved in planning their care.

The provider and registered manager had failed to design service users' care with a view to meeting their

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

A system to receive, investigate and resolve complaint was not in operation at the service. People and their relatives told us they knew how to complain and they would speak to office staff about any concerns they had. One person told us they had complained about the times of calls and this had been addressed by office staff. They told us they were now happy with the agreed times for calls.

An audit completed on behalf of the provider in August 2018 found that an effective process was not in operation. Complaints had been received but there was not records that they had been investigated and resolved to people's satisfaction. Action had not been taken since this audit to put a complaints process into operation that was fully understood by staff and there was a continued risk that complaints and concerns raised would not be resolved to people's satisfaction.

The provider and registered manager had failed to establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and others. This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The service was not well led. The failure of the provider and registered manager to effectively manage the service had placed people at risk of harm and abuse.

The provider understood the role of the Care Quality Commission (CQC) but did not fully understand the requirements of the fundamental standards. They had relied on the registered manager to establish the service and ensure it was delivered in accordance with regulations.

Expertise Maidstone is a franchise. The franchise agreement included checks and audits by the franchisor. The franchisor had completed two audits and found a number of the significant shortfalls in the organisation and delivery of the service. They had raised their concerns about the safety of the service with the provider, local authority commissioners and Care Quality Commissioning (CQC). The provider and registered manager had not been completing checks and audits and had not identified the shortfalls found by the franchisor.

A culture of openness had not been developed at the service and the provider had been unaware of any of the shortfalls until they were informed by the franchisor. The provider did not have the required oversight of the service. They had trusted the registered manager and had not checked that they were doing what was expected of them. Records of telephone conversations and meetings between the registered manager and provider had not been maintained so they could be followed up.

People and staff had been asked for their feedback about the service in the summer of 2018. Information received had not been used to improve the service. For example, people had raised concerns about communication and the out of hours response and staff had identified problems with a lack of information about people. We found that shortfalls in these areas remained.

The provider and registered manager had failed to effective systems to assess, monitor and improve the quality and safety of the service, including the quality of the experience of service users in receiving those services. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was not working at the service at the time of the inspection. Three staff, an assistant manager, coordinator and a senior carer were doing their best to manage the service on a day to day basis. None of them had experience of managing a care service. They did not have job descriptions and their roles and responsibilities had not been defined.

Staff were not clear about their roles and responsibilities. The provider and staff did not know what was expected of staff. For example, the job title 'assistant manager' was not an official title in the provider's staffing structure, there was no job description and neither the provider nor the staff member in the role knew what was required of them. They had not applied for the position and told us "All I was trying to do was help [the registered manager]". The provider did not know what training and development the assistant

manager had had for the role and if their competency to complete the role had been assessed. The assistant manager told us they felt 'overwhelmed' by what was expected of them since the registered manager had stopped working at the service and were striving to make sure that people received a call from a carer every day.

Staff were demotivated. One staff member told us, "I'm not very happy in this job at all" and they would no longer be working for the provider. The coordinator who was responsible for doing the staff call rota told us they had been "firefighting" since they began working at the service and were leaving a couple of days after our inspection. Another staff member told us, "Staff are tired of running late everywhere". Several more staff had resigned either shorty before or during our inspection.

Some staff told us they had previously felt supported by the registered manager but did not feel supported at the time of the inspection. Other staff told us they had not felt supported in their role. One staff member told us they had been nervous about taking on their role but had been assured by the registered manager that they would receive the training and support they needed. They told us they had not received any formal training or support and there were no records of supervision or training in their records. Staff told us that they came into the office regularly and could talk to the office staff if they wanted. We observed staff regularly visited the office to chat to office staff. However, most of the conversation was about personal matters and not people's care. One member of the office staff described the environment as "a girls' locker room" rather than a professional organisation.

When staff had accidents such as falling down steps in people's houses and car crashes on their way to calls, these were recorded in the on-call log but there was no further recording of the incidents or accidents. The registered manager and provider had not completed any analysis to identify trends and patterns, they had not taken any action to keep people and staff safe and minimise the risk of them happening again.

The provider and registered manager had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records of people's needs and the care were stored on an electronic system. The assistant manager told us they did not fully understand how the system worked and had a limited ability to find the information they needed. Several staff told us they had not been provided with tablet computers to access information about people and no paper records about people's care were maintained. They told us they relied on other staff and people to tell them about people's needs and the care they required. One staff member told us "It's not safe for us to rely on people telling us what they need".

Records of people's care and other important information were not up to date. One member of office staff told us they had had difficulty contacting people and staff when they were on call because the contact details were not up to date. The codes for key safes, for some people who were not able to answer the door to staff were not stored on the system and available to staff completing the call.

The provider and registered manager had failed to operate effective systems to maintain securely an accurate, complete and contemporaneous record in respect of each service user and staff member. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service like a serious injury or safeguarding concern. This is so we can check that

appropriate action had been taken. The assistant manager and other staff did not know that they were required to notify CQC of significant events. We had not received notifications from the service when they were required, for example with regard to the safeguarding concern identified at the inspection.

The provider and registered manager had failed to notify the Care Quality Commission about significant events. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager and provider had not collaborated with external stakeholders and other services. Systems were not in place to share and obtain information about best practice and service innovation to continually improve the service, for example the registered manager did not attend local registered managers support groups.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. This was the first ratings inspection completed at the service.