Caring for You Limited

Grove Domiciliary Care

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 inspection took place on 17, 27 and 30 June 2016. The inspection was announced.

Grove Domiciliary Care is a domiciliary care service, which provides care and support for people who live in their own homes. At the time of this inspection, they provided care and support to approximately 250 people with a range of needs including older people and those who lived with dementia. People were supported with personal care, medicines administration and meal preparation. The service employed 90 care workers which included six senior care workers who had each been delegated a specific geographical patch to manage. Their role was to oversee the care workers in their patch and cover on call out of office hours. There were also four care co -coordinators and administrative staff based at the office premises.

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

At our last inspection carried out on 30 January, 6 February and 23 April 2015, we found the service was in breach of four regulations. Records had not been completed when people had been supported to take their medicines, safe recruitment practices had not been followed, people's care needs had not been kept under review and the provider did not have an effective system to monitor the quality of service they provided. We asked the provider to send us an action plan to tell us how they would meet these regulations and what actions they would take to make improvements. The provider sent us an action plan on 8 July 2015, which stated they would be compliant with the regulations by the end of October 2015.

At this inspection we saw the provider had not completed all of these actions and we identified eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009.

People who used this service often received missed or late calls. They told us that this had started to improve during the week from Monday to Friday, but that at weekends and holiday periods it was still very poor. This had put people at risk of harm especially those who needed support with their medicines, meal preparation or assistance to get out of bed.

Staff did not always recognise or report safeguarding concerns and the service did not take enough action to avoid further incidents.

There were not always enough staff to meet people's needs, especially during weekends, holidays or in the event of staff sickness. People who had a regular named carer were the most satisfied with the service they received. We saw that the service had been trying to provide more people with a regular named carer.

Staff were not properly vetted before being allowed to work with people in their own homes.

When people were supported to take medicines staff did not always keep a record of this.

Staff did not receive enough training or supervision to meet people's needs or to ensure people's safety.

Although staff sought peoples consent before providing care and support, they did not demonstrate a good understanding of the Mental Capacity Act 2005, the associated code of practice and how this related to people they cared for.

People found staff were caring and told us that they respected their privacy and dignity.

People did not always have a written care plan at the onset of them receiving care. This had caused problems for staff and people who used the service and did not ensure that people received personalised care.

People's complaints were listened to. However, the service did not learn from past complaints or people's experiences in order to make the necessary improvements.

Staff found the registered manager supportive. However, the demands on the manager meant that important issues were not always dealt with and the manager did not always fulfil the legal requirements of a registered manager.

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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

Recruitment practices were not robust to ensure staff were suitable to work with people. There were not enough staff to meet people's needs.

The service had failed to identify and investigate safeguarding concerns and ensure all staff had followed procedures appropriately.

Medicines were not managed safely

Is the service effective?

Requires Improvement

The service was not always effective

Staff did not always have the training they needed to meet people's needs and ensure their safety. They had not had regular supervision.

Although staff sought peoples consent before they provided care, they did not understand their responsibility under the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not always caring

A number of recorded concerns meant that staff did not always demonstrate concern for people's wellbeing.

Staff respected people's privacy and dignity. People told us staff were kind and caring.

Is the service responsive?

Requires Improvement

The service was not always responsive

People's care and support plans were personalised and their preferences and choices were recorded in detail.

Care plans had not always been put in place at the start of someone receiving care and this placed at risk of receiving care, which was not in line with their needs.

Is the service well-led?

Inadequate

The service was not well-led

Staff told us the registered manager was approachable and supportive.

The service did not demonstrate good leadership or management.

The registered manager did not notify the Care Quality Commission of safeguarding concerns.

There were insufficient systems in place to assess and monitor the quality and safety of the service and to ensure that people received the best possible care in line with their needs and were not placed at risk of harm.

Grove Domiciliary Care

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 17, 27 and 30 June 2016 and was announced which means that we gave the provider 48 hours' notice of the inspection to ensure key staff were available to speak with us.

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 care service. The expert's primary area of expertise was with older people and people living with dementia. They had previous experience of assisting in the inspection of a range of different services including domiciliary care.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and safeguarding concerns.

We sent questionnaires to 14 community professionals and received four responses. We talked to 15 people who used the service and nine relatives.

We looked at the care plans and associated records of four people in detail. We looked at medicines administration records, six staff recruitment files, records of staff supervisions, and training. We looked at records of complaints, accidents and incidents, policies and procedures and quality assurance records.

We spoke to the nominated individual of the registered provider, the registered manager, four care workers and two care coordinators .

Inadequate

Is the service safe?

Our findings

People and their relatives told us they felt safe from abuse and harm from their regular care workers. However, they told us they did not feel as confident when their regular care worker was not available. One relative said, "There is a limitation to how safe I feel with [person's] care. I am not confident with the new ones, within the last two weeks a [care worker] came and could not differentiate between a medicine patch and a paracetamol. That was worrying."

Missed or late calls were a common cause for concern for the welfare of people who used the service. Sixteen of the people we spoke with reported they experienced late calls or missed calls. They told us what affect this had on them. One person said, "They are often late in the morning and I struggle to get out of bed until I have my medication so when [care worker] is late I get out myself and take my tablet and go back to bed until [care worker] comes to wash and dress me".
Someone else said, "[person] has not had a call yet (12 noon) to administer [person's] eye drops and check on [person]. It is supposed to be 10 am". The service confirmed that this was an internal error, where one of the care coordinators did not put the call onto the system. Following our inspection the provider told us this had been followed up with the staff member concerned in supervision.

Relatives told us that when the care worker was late or did not turn up people often administered their own medicines. In other instances, the relative had to attend to deliver the person's care and this included administering medicines.

Feedback from community professionals confirmed that people had been put at risk due to; late or missed calls, a failure of staff to follow care plan instructions and staff not reporting safeguarding concerns. Following our inspection, we were provided with evidence that demonstrated some, but not all, safeguarding and health and safety concerns had been raised by staff to the registered manager, and that follow-up action had been taken with relevant authorities. There had been several safeguarding investigations by the provider and the local authority in the months preceding and up to this inspection due to these concerns.

The overall feedback from external professionals was that people were not safe from abuse or harm from this service. One professional reported their awareness of a number of significant safeguarding concerns and felt people had experienced harm due to neglect. Another professional said they felt the service was disorganised, and that communication between the service and people and their relatives was poor. The professional reported that whilst staff may be trying their best, there were a number of missed visits, lack of following care plans and failure of the service to address staff shortcomings which meant that mistakes were being made in providing care and people were at risk of coming to harm.

The service had a 'Safeguarding Adults Policy' and we saw from training records that staff had received safeguarding training. Staff we spoke with had knowledge of the types of abuse, signs of possible abuse and their responsibility to report any concerns promptly.

The registered manager provided information which demonstrated that carers had reported some safeguarding and health and safety concerns to her and that follow-up action was being taken where needed. However, this was not a consistent practice.

There had been recent safeguarding investigations that found staff did not report incidents such as medicine administration omissions, health and safety concerns and in one case, they had not reported important information disclosed to them by a person who used the service. The registered manager was not able to provide any evidence that they had followed the provider's policy in investigating and taking appropriate actions following safeguarding concerns which had been raised. They had not provided staff with additional training or support when these omissions had occurred.

The failure to identify and appropriately investigate safeguarding concerns and ensure all staff were following appropriate procedures meant people were at risk and was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us there were not enough staff to meet their needs. They said care workers were often late, too early, or sometimes did not arrive at all. They said that weekends were the worst. They did not feel confident that care workers would arrive, what time they would arrive or who the care worker would be.

During one conversation with a relative, they told us they were concerned, as the care worker had not turned up that morning. They told us the care worker had been due at 9am and when we spoke with them at 11:30am, they had not received any communication from the service to let them know the care worker would be late. We contacted the registered manager immediately to inform them. They told us they were unaware that the care worker had not turned up. The relative had to provide the person's personal care. They told us the regular carer worker kept them informed if they were going to be late but if they were not available then they did not know who would be coming or when. They said this caused their relative to become, "anxious."

Staff told us there were not enough care workers at the weekend in particular. They said it was often due to staff going off sick at the weekend. Comments included; "At the weekend I can work from 6am to 11pm with a one and half to two hour break". "Weekends…they are the worst… they can be horrendous". They told us that they were often given additional visits to make which meant people had late visits. Staff said that it had started to get better during the week Monday to Friday when they considered staffing levels were generally sufficient.

One professional reported they had received accounts from people and their carers that care calls were often at the wrong time to meet people's needs. Calls were, 'too early', 'too late', 'too close together' or 'too far apart'. Another told us they had received complaints from people regarding late calls and that the service 'struggled' at weekends and holiday periods. They did not think there were any contingency plans to allow for changes in staffing levels. However, we saw the service had an on call carer who had no scheduled calls and could cover calls at weekends. The service also had a second on-call carer as a back-up should this be required.

It was unclear from care plans and assessments as to the actual time that people required their visit. For instance in one person's file it was recorded that their 'contracted hours' were for half hourly visits 9:30 am to 10am seven days a week. This contradicted with their original assessment that recorded they required a 7am to 7:30 am call. We looked at the care records for the period 1 May 2016 to 6 June 2016 for this person. We saw they required support with personal care that included a shower and getting dressed. During weekdays Monday to Friday, the majority of visits had commenced at 07:15 to 07:45. However we noted on

12 occasions during this period visits had commenced much later, with the latest being 1:45 pm. Ten of the late visits were at weekends. One Sunday there was no record that the person had received a call.

It was recorded in another person's care plan they required four half hour visits a day seven days a week. We saw they required an evening visit for support with personal care that included support with having a wash and getting ready for bed. The care plan showed the visit should commence at 7:30pm. We looked at their care records for the period 1 May 2016 to 25 May 2016. We noted only six occasions during this period when visits had commenced by 7:30pm. For one day, there was no record of a visit and the latest visit had been at 10:30pm.

We looked at care records for other people and saw further evidence people had received late or missed calls.

The registered manager told us they had a permanent advertisement out for care workers and were constantly trying to recruit more staff.

The failure to deploy sufficient numbers of staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment practices were not followed before new staff were employed to work with people. At our last inspection in 2015, we found that recruitment practices were not robust to ensure staff were suitable to work with people. This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponded to Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan and told us that as of 08 July 2015 this had been rectified. However at this inspection, we found recruitment procedures did not meet the standards required by the regulations.

We looked at the recruitment files for six members of staff. Disclosure and Barring Service (DBS) checks had not been carried out for three of the staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable staff from working with people. For one staff member there was only evidence that a request had been made to the DBS. For another staff member there was a DBS certificate on file from their previous employer with no check made against the Adults Barred list. This is a list of people who have been barred from working with adults. For a third member of staff there was no evidence that a DBS check had been carried out. A fourth member of staff only had a DBS certificate from their previous employer dated June 2015. The contents of that DBS showed that there would have been a need to consider carefully their employment with the service. In addition to that, the provider had not carried out their own DBS check to ensure this person was suitable to work with people in their own home. The service had a risk assessment in place for this member of staff.

Only one reference had been obtained for four of the staff and there were discrepancies with two of these. Evidence of identification had not been obtained for two of the staff.

The registered manager informed us on 8 July 2016 that a fourth member of staff did have a valid DBS certificate however they had not brought this in for the manager to check. The member of staff brought in the DBS certificate the day after the inspection. The service had a recruitment policy and procedure that stated, 'New staff members, including any temporary staff, will not be offered a position within the company until the following checks have been carried out:- Verification of identity, Criminal Records Bureau Check, POVA check (where the position is for a "regulated position" – i.e. personal care)Two suitable references…'.

This procedure had not been followed and no audit had been completed to verify that all the information had been received before the staff members had been allowed to work with people.

Because of these concerns, we raised a safeguarding alert to the local authority.

The failure to carry out pre-employment checks on staff meant that we could not be assured only suitable staff worked with vulnerable adults and was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in 2015, we found that people's medicines were not managed, or administered safely. This was due to the fact that medicines administration records (MAR) were not always completed. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponded to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan in July 2015 and told us would be this rectified by the end of October 2015. They told us all staff had received medicines training (to include completing MAR Sheets). The action plan stated, 'We will be implementing medication competency tests which will be undertaken by senior care staff'. They also said they would complete monthly audits of the MAR.

At this inspection, we found that the provider had not made all of the improvements as stated in their action plan.

The registered manager told us that MAR were now collected and audited monthly as had been stated in their action plan. We asked to see the MAR for four named people for the period 01/05/16 to 31/05/16. The registered manager could only provide three as the fourth had not been collected or audited. None of the three MAR had been completed correctly. There were many gaps where staff had not signed to state the person had received their medicines. Staff had not used any coding to indicate why the MAR had not been signed. (There was a list of codes printed on the bottom of each MAR for staff to use in the event they did not administer or prompt someone with their medicines).

We could not find any evidence that MAR records had been audited or that any action had been taken because of these omissions. The local authority had also raised this issue following recent safeguarding investigations.

The registered manager showed us examples of other MAR that had been fully completed and told us that they felt since June 2016 the situation had improved.

The failure to ensure medicines were administered and recorded safely was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

Staff did not always have the training they needed to meet people's needs and ensure their safety. People told us that they felt the care staff were well trained and had the skills to meet their needs. Comments included; "Yes my [person] has to be helped to move around and their understanding and skills at this are good". "They have to use the hoist for me they are all different carers but they all know how to use it", and, "My regular carers are very good, they are skilled in what they do and well trained".

One person told us, "The regular carers use the hoist well and are well trained but last week they sent two new ones, who although were trained didn't know exactly what to do. I don't mind having new ones or different ones as long as they know what they are doing." Another person said, "My [person] has very complex needs so I initiated some training at my house with [person's] tube feeding so now I am confident in the staff being able to deal with [person]".

We saw that the service did not ensure that staff had undertaken all core training before they worked with people. Staff told us they had received training and had the skills they needed to meet people's needs. However, this was not consistent with our findings. Staff said they did regular refresher courses and felt the training they received was sufficient to meet the needs of people. We saw a 'staff training matrix'. This listed the date that each staff member had completed core training. The registered manager explained they used this to plan, monitor and prompt when staff needed to undertake refresher courses for core training. We also looked at four care workers staff training records. We found that most staff had completed a range of core training that included, safeguarding, fire safety and moving & handling, food hygiene, medication and infection control. However not all staff had received training on manual handling before they started working with people. In three out of the four files we looked at there was no evidence that the care worker had completed moving and handling training. Two of the staff had been working at the service since July 2015 and one started in April 2016. It was evident that this had not been brought to the manager's attention.

One external professional reported they had not seen evidence that the training staff received prepared them for their role. They told us they were not certain whether staff received sufficient supervision or whether staff were monitored sufficiently to make sure they had they required level of competence.

Staff had not until recently been supervised to evaluate their competence and assess their training needs. The registered manager had delegated the supervision of care workers to the four senior care workers. The registered manager said that staff supervision consisted of a general supervision, a spot check (A spot check is an unannounced check carried out to see if staff are carrying out their duties as per policy, safely and that they are conducting themselves in the proper manner) and a medication competency check.

From records and discussion with staff, they had not had recent and regular 1-1 supervision. One staff member said they had supervision, "About six months ago" and two others told us they had not had supervision recently. Three of the four care workers we spoke with had received a spot check the week of our inspection. One commented this had been their first ever spot check. Staff said that they felt supported and that they found the registered manager supportive.

We talked to a senior care worker. They told us they had been allocated 25 spot checks on care workers to complete and they had completed 19 within the last three weeks. The registered manager provided us with a list of 74 care staff out of the 90 employed who had received a recent spot check within the last month. It was evident that this had been lacking previously to this. The local authority had highlighted this during safeguarding investigations and quality checks. It was clear that the service was trying to improve in this area.

However, staff whose practice had been identified as lacking through, omissions in medicine recording, safeguarding investigations or concerns raised by people who used the service had not received additional supervision or training in order to improve and monitor their practice. This did not provide people who used the service with sufficient safeguards. □

The Mental Capacity Act 2005 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 Act.

We looked at the files of four people. We saw evidence that the service had sought each person's consent before they provided care or support to them. People had signed an agreement to receive care and support and there was evidence that this had been explained to them. We talked with staff and they told us that they only provided support to people who had given their consent for them to do so. People who used the service reiterated this. One person said, "If I need help with dressing they will help me. It is up to me".

Staff confirmed they understood the need to gain people's consent before providing care. They provided examples of how they did this. They told us if someone decided they did not want an aspect of their care, they would respect this. Examples given included when someone had told them they would prefer not to have a wash or shower. They told us they would offer an alternative or ask them again a bit later. They said that they found that often the person had changed their mind and would agree to have a wash. They told us if they still refused, they would respect the person's wishes and record this, and inform the office if appropriate such as when someone refused their medicines.

The registered manager was aware of the Mental Capacity Act 2005 and its associated code of practice. They told us that staff received training in mental capacity as part of their induction and were aware of the principles of the Act. However when we asked care workers about the Mental Capacity Act none of them could remember doing the training and only one of the four care workers spoken with demonstrated any knowledge of the Act.

We asked external professionals if in their opinion the service's managers and staff understood their responsibilities under the Mental Capacity Act. Two responded that they did not know and two answered, 'no'. There had been safeguarding investigations where staff had not recognised the need to pass on concerns about people who lacked the capacity to make decisions. Therefore, people were not adequately protected from the risk of coming to harm as care workers lacked an understanding of the Mental Capacity Act and did not recognise their responsibility when someone lacked capacity to make decisions. There had also been recent safeguarding investigations regarding staff failure to record or pass on concerns where people had not had the capacity to ensure sufficient fluid intake. One external professional told us they were aware of repeated instances where staff had not realised their responsibility to pass on concerns for people who lacked capacity to make sure they had sufficient fluid intake.

There was no evidence that plans had been put in place for care staff to do refresher training on the Mental Capacity Act 2005 in particular those staff who had been identified through safeguarding investigations as needing such training.

The failure to ensure that all staff were appropriately and effectively trained and supervised to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans provided information about what support people needed with eating and drinking. There were risk assessments in place where people were at risk of malnutrition or dehydration. Training records showed staff had received food hygiene training. Generally, people were happy with the support they received. However a relative told us, "The afternoon staff appear to be rushed and sometimes forget to do things for instance [person] likes soup with their meal and I prepare it and keep it in the fridge in date order but they cannot be bothered to look they just take any one".

People and their relatives said they organised GP and hospital appointments themselves or for their relatives. Staff told us they monitored people's care and health needs. Staff said if they had any concerns they either passed the information back to the service or contacted health professionals such as GP's or emergency services as appropriate. Important contact details such as GP's and peoples medical needs were recorded in the care files held at their homes. One person said, "They are very good, recently... [person] was taken poorly and the carers called an ambulance and phoned me".

Requires Improvement

Is the service caring?

Our findings

Everyone who used the service and their relatives said that their regular care workers were caring and respected their privacy and dignity. Comments included, "My regular carer is like a daughter to me. I have no family she is so good to me… I would be lost without her". "My carer is absolutely lovely and very caring". "My [person] cannot communicate but that does not stop the carers from communicating with [person]" and "I have very nice carers we have a laugh and a joke, I don't always know who is coming but I don't mind".

Whilst people's day to day experience of care was good for those who talked to us, we identified through reviewing records that people who may have lacked capacity to express concerns had been exposed to the risk of harm in some specific incidents and staff had not always demonstrated concern for people's wellbeing.

People told us they did not always know who was coming to visit them and a number of missed and late visits without informing people meant that sometimes people's needs were not responded to quickly enough.

We saw that the agency had been making an effort to provide more people with a regular care worker. People we contacted who had a regular carer expressed the most satisfaction with the service. The care workers we talked with told us they had people that they visited regularly and through discussion, they demonstrated that they understood their needs. One care worker said, "You get to know them and get a bond with them". When we asked staff what they enjoyed about their job they commented, "Every day is different", "The people", and said the care they provided allowed people to stay in their own homes.

An external professional told us, "I have met one or two carers from the care agency and the ones that I have met have been very kind and caring towards the people they care for".

Staff respected people's privacy and dignity. One person said, "Yes they respect my privacy they put me on the commode in the bathroom then they leave me". A relative told us, "They respect [person's] privacy and dignity they don't allow me in the bathroom they close the door on me and I have to knock"

Staff confirmed they understood and valued the need to respect people's privacy and dignity. They described the methods they used when supporting people with personal care such as; covering people with towels, undressing them in bathrooms so that they did not compromise their privacy.

The agency had a confidentiality policy and each member of care staff had signed to say they had read the policy. Staff had been provided with a 'staff handbook' and this contained a copy of the policy. We saw that people who used the service had been given a copy of the policy also. Staff were able to explain their understanding of the policy.

Requires Improvement

Is the service responsive?

Our findings

People's care and support plans were personalised and their preferences and choices were recorded in detail. Care plans were written in the first person and this helped to describe people's care needs from their perspective. An example being, 'I will be in bed on arrival, wake me gently and turn on my main light…' The care plan then described the different stages in the support process such as how to support the person to get out of bed and the equipment to be used and how they should be supported to wash and dress. The care plans we saw provided details of the people's abilities as well as their support needs.

At our last inspection, we found that care plans had not been reviewed regularly. At this visit, we found reviews had been completed. However, the local authority informed us that care plans had not always been put in place at the start of someone receiving a service. Consequently, this had resulted in safeguarding investigations, as staff did not have the information necessary to provide people with personalised care. Some people we contacted confirmed they or their relative had not had a care plan until a long time after they started to receive care and support from the service.

A relative, whose loved one had received care from the service since September 2015 told us, "Two carers came recently to set up the care plan they did not tell me they were coming they just arrived [person] was quite upset". We saw one care plan for someone who had started receiving care from the service on 9 April 2016. Their care plan was dated 12 May 2016.

The local authority had been closely monitoring the situation regarding care plans and had agreed an action plan with the service. At a meeting after this inspection, the service confirmed every person now had a care plan in place. In discussion with care workers, they agreed that care plans had not always been available for people they had visited. They confirmed that everyone they visited now had a care plan.

The failure to ensure that each person had an up to date care plan in place was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence staff had carried out an initial assessment of each person's needs before providing them with a service. Where relevant an assessment from the funding authority had been obtained. This was intended to prevent the agency from providing a service to someone whose needs they could not meet. However, people did not always receive a call at the time specified in their assessment.

Many people complained to us about missed and or late calls. Comments from relatives included, "I don't trust the carers to come on time I have to try and pop in on [person] during the day to ensure she has had a visit".

"Weekends, half terms along with if [person's] core three or four care workers are sick is challenging. It just all falls to pieces they are late or do not arrive and you never know who is coming. Over Christmas no one came".

"My [person] usually has the same double- handed call but like last night, two girls were off sick. Then I think Groves are stretched they had to call in two girls who had the day off. The carers were fed up with this and the tea time call turned into 7pm".

"Weekends [person's] care is sometimes very late or missed altogether. They don't let me know; when I enquire they say there was a staff crisis".

People who used the service commented, "They have not turned up a couple of times, Grove ring me the next day".

"Sometimes they don't come. I keep an eye on the clock and if it goes well past the time I just get on with it myself, no one phones me".

"Saturday and Sundays are another story. Timings are not good, one Sunday for my morning call they arrived after 2pm no one calls".

"The office knows what I want but every Monday they come late. It is supposed to be 9 to 9:30 but they come around 11.30. I cannot shower or wash myself so I have to wait".

Complaints and concerns were taken seriously. However, they were not used as an opportunity to learn and make improvements in the service. People told us they would not have a problem knowing who to complain to as many had done so already. People and their relatives told us they knew about their right to make a complaint. They told us they had the contact details to use if necessary. The registered manager said people were provided with the complaints procedure at the start of receiving support. We saw recorded evidence on care files to support this. The registered manager maintained a complaints log, which showed that any concerns or complaints had been responded to.

However, the service did not demonstrate that they learnt from complaints. We saw from the complaints log that when complaints had been made about care workers, the service changed the care worker and allocated them to work with someone else. Although we did not identify that any of these complaints were about harm to people there had been no further action other than a change of care worker.

The failure to take appropriate action in response to complaints 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

People and their relatives told us there was no regular contact with the registered manager or senior staff. People described the service as 'disorganised' and commented that there had been many changes to staff recently. When asked if there was anything the service could do better only two of the 24 people said, "No". People identified a number of common themes that they felt needed to be improved. These were, communication, more care staff with quality put first, and better organisation.

One external professional who worked closely with the service told us there seemed to be too much responsibility placed on the registered manager with them having to deal with, "too many queries". They felt that some of the office staff struggled to deal with complex enquiries.

Another professional said from their observation the management struggled to lead the staff. They considered there to be a distrust to delegate tasks to enable the service to manage the numbers of care staff they employed.

Staff told us the registered manager was approachable and supportive. They said if they had a problem, the registered manager would do their best to help. They told us they felt the registered manager was doing too many roles and did not delegate to other staff as they did not have the confidence it would be done. One staff member said, "The manager is very busy, doing rotas, and doing the coordinators role, they [the coordinators] are not pulling their weight".

The registered manager had been making changes within the office and working with office staff with the aim of them taking more responsibility.

At the request of the local authority, the registered manager was working with the local authority to complete an action plan to ensure the safety and welfare of people. This was monitored through regular quality review meetings chaired by the local authority. From talking with the registered manager, it was evident that they had been very involved with safeguarding issues and concerns and this had taken up a lot of their time.

One external professional said the service did not have strong leadership. They told us this had resulted in office staff and care workers working in a chaotic environment and that no one appeared to take responsibility for, "Anything".

The nominated individual of the provider supervised the registered manager and worked with her closely, visiting the service every week. However, the nominated individual was also the registered manager of another service within the organisation. There was therefore a limit to how much support they could provide. The nominated individual was particularly involved in the tendering and implementation of a new contract in and around February 2016. She had worked extensively with social services and had attended safeguarding meetings. However, this support had not always ensured the service was fully compliant with the regulations.

The Commission had received several safeguarding concerns about the service. The registered manager had not notified us about all of these The registered manager advised they did not know that we needed to be notified of the safeguarding concerns.

The failure to notify the Commission of safeguarding concerns was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider did not have effective systems in place to monitor the quality of care and support that people received.

At our last inspection in 2015, we found that the service did not have an effective system to monitor the quality of service they provided. Auditing systems were not effective and did not identify where improvements were needed. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponded to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan in July 2015 telling us they would be implementing an 'improved auditing system'. At this inspection, we did not find any improvement in this area. The provider had sent out quality questionnaires to people in December 2015 and the responses to these had been analysed. However auditing procedures which had been introduced had not identified the shortfalls in areas such as medication recording, staff recruitment checks and staff training which we had found.

The failure of the service to implement the changes as specified in their action plan in relation to the breaches of regulation found at the previous inspection, demonstrated that the management of the service was lacking. Alongside this, we identified further breaches in regulations that have placed people at risk of harm.

The registered manager told us they completed a monthly audit tool for their line manager. The nominated individual of the provider told us they visited the service and checked records. However, neither processes had identified the shortfalls as identified in this report.

The failure to ensure that there were effective quality assurance and auditing systems or processes was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC of safeguarding concerns. Regulation 18 (2) (e)

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not put in place for people at the start of them receiving a service. This did not ensure people's needs would be met or that they would receive safe and effective care. Regulation 9 (1)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding concerns had not been identified, reported and appropriately investigated. Regulation 13 (1)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Appropriate action had not been taken in response to complaints. Regulation 16 (1)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Appropriate arrangements were not in place to ensure that a record was kept of all medicines administered. Regulation 12 (2) (g)

The enforcement action we took:

warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was not any system in place to assess, monitor and improve the service. Regulation 17 (2)

The enforcement action we took:

warning notice

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not operate an effective recruitment procedure to ensure staff were suitable to provide care to people. Regulation 19 (2)

The enforcement action we took:

warning notice

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to meet the needs of the people who used the service. Staff did not receive all necessary training or regular supervision to enable them to carry out the duties they were employed to perform or to meet people's needs.

Regulation 18 (1) (2) (a)

The enforcement action we took:

warning notice