Sage Care Limited

Sagecare (Biggleswade)

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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an announced comprehensive inspection of this service between 6 and 13 June 2016. After that inspection we received concerns in relation to medicines administration, missed and late care calls, poor care, poor communication and unacceptable attitude of office and senior staff. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics, although the topics affected each of the five areas we look at, safe, effective, caring, responsive and well led. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Sagecare - Biggleswade on our website at www.cqc.org.uk.

The service provided personal care for people in their homes. At the time of our inspection the service provided care and support to 359 people.

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. The registered manager was also the provider's regional manager and was not at the service on a daily basis. Day to day management of the service was the responsibility of the branch manager. It was following the sudden departure of a newly appointed branch manager that we saw an escalation of the number of concerns that were raised with us.

People felt that they were safe using the service and trusted the staff that cared for them but there was an insufficient number of suitably trained staff to provide the care that people needed. There had been numerous occasions when people's care calls had been late or missed altogether. The call monitoring records showed that, where people required two care workers to provide the care they needed, often only one care worker was scheduled to attend their call. This had resulted in people being unable to receive the care they required. The records also showed that many calls were shorter than the length of time scheduled. Care workers were not allocated sufficient time to travel between calls and this had resulted in people's care being rushed as care workers tried to make up the travelling time. A new call monitoring system was to be introduced with effect from 7 November 2016. The provider was confident that this would enable calls to be better managed and monitored.

The recruitment process for new staff was not robust. The recruitment documentation did not always contain evidence of the staff member's right to work in the United Kingdom or have validated references from previous employers.

Risk assessments had not been completed accurately and did not always reflect all the risks that people were exposed to because of their health and care needs. Neither accidents and incidents nor complaints had been recorded in the appropriate systems during 2016 so the provider was not aware of these and action to reduce recurrence could not be identified. Complaints were not resolved to people's satisfaction.

Staff had been trained in safeguarding but the acting branch manager had failed to notify CQC of a number of safeguarding incidents. People had mixed opinions as to the skills of the care workers. There had been a number of occasions when staff had provided inappropriate care to people. Staff had positive relationships with people they cared for on a regular basis. People were less happy with the attitude of staff when they did not have regular care workers or when their regular care workers were not available.

People's care plans were not updated following changes to their needs and services commissioned on their behalf. The documentation was not sufficiently detailed or always filed correctly. The quality assurance systems in place had failed to identify many of the concerns and where these had been identified no action had been taken to address the concerns.

During this inspection we identified breaches of a number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took urgent action to impose a condition on the provider's registration to prevent the service from taking on any new packages of care without the CQC's written agreement to protect people from the risk of harm.

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.

There was an insufficient number of suitably trained staff to meet people's needs and as a consequence care calls were cut short or missed. Where people required two care workers to provide their care the calls were often attended by only one care worker and as a consequence the appropriate care could not be given.

The recruitment process was not robust.

Risks to people were not always identified and assessments were not always completed accurately.

People's medicines were not always managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always have the skills needed to provide care to people.

Although staff were supported by way of supervisions the documentation of the meetings failed to evidence what had been discussed.

Is the service caring?

Requires Improvement

The service was not always caring.

People found that staff attitudes towards them were variable. Regular care workers were caring but people who did not have regular care workers found that some were unpleasant to them.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans did not reflect the service that was provided. The care plans had not been updated when commissioned services had changed to reflect people's changing needs.

Complaints were not dealt with in accordance with the provider's policy. Complaints were not recorded and people were dissatisfied with the responses that they received. People were made to feel guilty for making a complaint

Is the service well-led?

Inadequate

The service was not well-led.

Concerns that had been identified through the provider's quality assurance processes were not addressed.

The quality assurance process had failed to identify errors and failings in the care documentation.

The service had failed to submit necessary notifications to CQC.

Sagecare (Biggleswade)

Detailed findings

Background to this inspection

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

We had received concerning information about the service and an initial inspection visit took place on 6 October 2016 which focussed on the concerns that had been raised. These had included a medicines administration error so serious as to be life threatening and resulted in a hospital admission. Another concern was a missed call following a person's discharge from hospital. The person fell, during which they sustained broken bones, and they were lying on the floor all night.

The inspection visit was unannounced and was carried out by three inspectors. A further unannounced visit by the three inspectors was made on 14 October 2016. An Expert by Experience made telephone calls to people and relatives of people who used the service on 17 and 18 October 2016. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information available to us, such as notifications and information provided by the public or staff. A notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with 15 people who used the service, nine relatives of people used the service, three care workers, a senior care worker, two care coordinators, the acting branch manager, the registered manager and the provider's Director of Quality. We reviewed the care records and risk assessments for 12 people. We looked at staff recruitment, training and supervision records. We also reviewed information on how the quality of the service, complaints and incidents were monitored and managed.

Inadequate

Is the service safe?

Our findings

People we spoke with consistently told us that when their regular care workers did not attend, calls were often late. One person told us, "On the rare occasion that one of my regular carers is running late, they will always phone me to let me know what is happening. When it's not one of my regular carers, it's usually me that has to ring the office to find out what is happening." Another person said, "We did have a number of occasions when the carer hadn't arrived some two hours after they were supposed to be here. I did ring the office and was told that they were on their way, but another hour later when they still hadn't arrived, I rang again to be told that unfortunately there was nobody available and I would have to manage." A third person told us, "I think if it weren't for the fact that I promptly get on the phone every time a carer is an hour late, that there would be far more completely missed calls than I have experienced of late because I make it clear to the office that I definitely need somebody, whatever the time is when they get to me." A relative said, "My [relative] was having lots of different carers who would arrive at all sorts of time."

Following the inspection the provider sent by email a number of quality assurance monitoring records completed by the service. We reviewed a random sample of 33 of these records; 14 monitoring visits, 18 monitoring telephone calls and one unspecified monitoring record. Of the 14 visit records, five people told us they had missed visits. This was 35% of the people visited. However, none of the people called by telephone reported missed visits. The 33 records reviewed also showed us that 12 people were not told if their care worker was late (36%) and 14 people (42%) were not told of a change to their care worker.

We saw that some care calls had been arranged in a way that gave staff a travel time of five minutes in between calls. We noted that the actual travel times were greater than the planned times. One member of staff told us that travel time could be as much as 20 minutes between calls at certain times of the day. This meant that staff were late for visits after the first care visit of the day if they had stayed for the allocated time and this was reflective of what we found. One relative described the impact upon their family member of having late calls. They said, "They are supposed to come in the morning at 9.00am but some mornings wouldn't get to us until nearly lunchtime. That's far too late for [relative] to be still sitting in [their] nightdress and [their] incontinence pad is usually absolutely soaked by then." The visit logs for one person showed a total of five missed visits from 1 October 2016 to the day of our inspection with late and short calls occurring on a daily basis. One person who's evening call was missed had a fall in which they had sustained a broken hip whilst attempting to care for themselves. They were found on the floor the following morning, cold and in pain.

Call logs for one person who was supposed to have a 30 minute call every morning showed that during the month of July 2016 they had received a call for the correct length of time only five times. On one occasion the care worker had stayed for just five minutes.

We reviewed the call records for a number of people who used the service which showed us the planned times for people's calls and the times that staff had logged in. We found that the consistency of these varied for each person but that the data was not always accurate. Staff were required to log in to the system to indicate their times of arrival and departure but the data was frequently input manually either because the

person being visited did not have a land line, would not give permission for staff to use it, or staff had forgotten to do so. The data input manually did not always represent an accurate picture of the times involved. This data showed that on some occasions when people needed two care workers to safely provide the care they needed, only one care worker attended. The records showed that over a period of nine days, immediately prior to our inspection, one person who required two care workers at each call had been sent only one care worker 15 times out of 35. On five occasions single care workers had been scheduled to attend one after the other. The duration of time the call lasted within the record was also often incorrect. For example, one visit which was from 20.57 to 21.17 had been recorded as lasting 33 minutes when it was in fact only 20 minutes. Another visit that had started at 15.54 and ended at 16.25, a total of 31 minutes, had been recorded as lasting 52 minutes.

At approximately 9:30am on the first day of our inspection the call monitoring system showed that there were 38 care calls that had not been covered for the day, although by the end of the day these had all been covered. A further 119 calls over the following three days had also not been allocated at the start of our inspection.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough trained staff to provide care at the times people wanted it. One person told us, "I've actually complained to the agency about this but they have simply said to me that they haven't got any more carers and the only alternative is for me not to have anybody." A relative told us, "I said that we would like just a small number of regular carers who would arrive at the time they were supposed to, but I was told that there was little they could do at present because they were short staffed and I would have to put up with it. If I could find another agency to cover our area, I would do, because it's really not fair to my [relative] who is [age] and really doesn't understand what is going on." Another relative told us, "I have complained about missed visits, but to be frank, I was simply told there was nothing they could do about it without more staff, and they don't seem to have a plan for tackling the problem from what I've seen so far."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment records of three members of staff. We found that the recruitment procedures were not always robust. The application form contained a literacy and numeracy test. For two of the three members of staff there was no evidence that this had been assessed by the provider as to whether the staff had passed or failed. One record had no information as to the person's right to work in the United Kingdom. A second record contained references purporting to have been provided by the applicant's previous employer but these were not stamped by the company nor were they on headed note paper. They had not been validated and the provider could not therefore be assured that they were authentic. People may have been cared for by care workers who were unsuitable for the role.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicine was not being managed or administered safely. Records we looked at showed that one person had raised concerns about their time critical calls for the administration of their medicines being late on a number of occasions. Instruction to staff regarding support with taking medicines was not sufficient and sometimes inaccurate. This was a key factor in an incident where a person self-administered an overdose of insulin prepared by staff. This had resulted in a life threatening situation and the person was admitted to

hospital as an emergency.

We found a number of instances where people required creams and lotions but no instruction as to where to apply the cream was in place. In some of the medicine administration records (MAR) we looked at we found they had been inaccurately completed. Incorrect codes had been used and some were not completed for the application of creams and lotions. In one instance we found that a person had not taken a medicine for a week but no action had been taken by the service to follow this up.

Although some aspects of the medicines management training for staff was robust it did not explicitly cover areas of support that staff must not be engaged with such as preparation of the dosage of invasive treatment. The medicines policy described levels of support to administer medicines but did not specifically cover the preparation of a dosage of medicines to be taken via an invasive route. However, one member of staff told us that their training had identified some things that they were not to do when administering medicines.

In one care record the medication risk assessment stated that the assistance required from care workers was level 3, which meant complete medication support was required. The MAR had not been completed. We checked the care records daily notes from 03/05/2016 to 04/07/2016. Some entries indicated that person had taken their medicines before the care workers had arrived. Other entries indicated that medicines had been left with the person who said that they would take them later. Other entries made no reference to medicines at all. The management plan to mitigate the risks associated with medicines administration was not being followed and the person was not protected from the risk of failing to take their medicines.

We found that although personalised risk assessments had been carried out for each individual, the risk management process was not always effective. For example, one person had been assessed as being at low risk of pressure ulcers but was then noted to be receiving treatment for pressure ulcers. Another person was assessed as 'sometimes being at risk of choking', with no guidance to staff about how to assess this. There did not appear to have been any involvement with a dietitian or the speech and language therapists with regard to implementing a soft diet. There was also no information as to how care workers should identify if the person was experiencing difficulty with swallowing before offering them a cooked meal, such as ham and potatoes, or sandwiches. Some of the risk assessments that had been carried out were inadequate. One person's mobility risk assessment had stated that they had no visual impairment but the local authority plan in January 2016 clearly stated that the person was visually impaired. The environmental risk assessment in one record had been documented as referring to the kitchen and lounge areas. The tasks that care workers were to complete included making the person's bed and making a cup of tea and taking it upstairs. There were no risk assessments for the stairs, bedroom or bathroom. We saw that where a person was living with diabetes there was no related risk assessment in place or information as to how the risks associated with the condition should be managed.

While there was a formal system for logging incidents and accidents we found that this had not been used since 2015. We had been made aware of some incidents, including some of a safeguarding nature in 2016 by third parties but these had not been recorded in the provider's system.

Poor medicines management, inaccurate risk assessments and risk management plans and the failure to record or action incidents were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they had received training in safeguarding people from harm and were able to tell us of the types of abuse people to which people could be exposed. The provider had clear, up to date policies on

safeguarding and whistleblowing. Whistleblowing is a way in which staff can report misconduct or concerns within their workplace without fear of the consequences of doing so. However, due to the lack of formal recording of incidents and accidents it was not possible to establish whether or not all safeguarding matters had been identified and treated as such. However, of the safeguarding issues that we had been made aware of, we were not notified of two of them and were notified a month after the event for the other two. The branch manager had not recognised all of these as safeguarding matters.

Failure to notify CQC of a safeguarding incident is a breach of Regulation 18 of the Care Quality (Registration) Regulations 2009.

We had brought these matters to the attentions of the registered manager and the provider's Director of Quality during the course of our inspection. On the day of the second visit the registered manager told us of steps that they had taken to address our concerns about missed and late calls. These had included the setting up a team of three people who were responsible for checking the electronic call monitoring system from 7.00am until 11pm from 10 October 2016 in addition to existing monitoring systems. These people monitored for alerts that a care worker may have failed to arrive at a visit and also made contact with the care workers to check that they were completing all their scheduled visits. At the weekend the service had a pool of paid on-call care workers who would attend visits at short notice if a care worker could not complete their scheduled calls.

The service had already commissioned a new call monitoring service that would enable care workers to swipe a card as they entered and left a person's home. This would record the actual times of the visit automatically. This was to be introduced effective from 7 November 2016 and the provider was confident that they would be better able to monitor the service provision. The director of Quality told us that where this had been implemented in other parts of the provider's organisation compliance with visit times being recorded had increased to 90-98%.

The registered manager told us that the routes care workers travelled and the time taken between each visit would be looked at as the new call monitoring system was introduced.

On the second day of our inspection we looked at the records of accidents and incidents which had started to be completed. We noted that a record had been raised for incidents that had occurred on 03/10/2016 and10/10/2016. Investigations were on-going.

People and their relatives felt that they were safe using the service and trusted the staff who cared for them. One person said, "I have a key safe so my carer can let herself in of a morning and then she locks the door back up when she leaves and put the key back in the key safe. I have never had a problem with this and find it is the best way to allow all the different people to have access to my home without having to cut lots of keys." Another person said, "I have never had any issues whatsoever around the trustworthiness of the carers. My regular carer in particular, I would trust with anything." A relative told us, "My [relative] has used a key safe for many years and I have to say we've never had a problem at all with security." People were able to identify that staff were from the agency by their uniforms and the identity cards that they wore. One person said, "They all arrive with their uniforms on their ID badges on. I've never had anyone who didn't."

Requires Improvement

Is the service effective?

Our findings

The provider obtained regular feedback from people to check that their care was being provided in accordance with their wishes and in the majority of instances this was fed back to be the case. During the inspection we spoke with 9 relatives and 15 people who used the service and they had mixed opinions as to the skills of the care workers. People were happy with the skills of the regular staff who called on them but were less happy with new care workers. One person told us, "My regular carers are lovely and I know just how much support I need each morning." However, another person said, "Most often at weekends or to cover holidays or sickness, I can see carers who I have never seen before. I know it is a struggle for them but it's also a struggle for me to have to explain every single time to someone new what it is I need help with." A third person told us, "Most of the carers who have worked for the agency for some time, I think, have sufficient skills and training to do everything that I need help with. We reviewed the providers training and assessment of new care staff and could see that staff were provided with a comprehensive training programme that included competency checks prior to providing care.

A relative told us, "I have had to send people [care workers] home. They have not been trained to give help and don't know how to use the hoist. They get it okay for a week or two and then send them [care workers] on." However, another relative was more positive saying, "My [relative]'s carers are very well trained particularly in the use of the hoist and when one of the regular carers is off on holiday or ill then they will usually send a new carer with the regular carer so that she can learn how to use the hoist from my [relative]'s regular carer."

Prior to the inspection we had been made aware of an incident where a person had fallen and cut themselves. A care worker had inappropriately dressed their wound with paper tissue secured by sellotape. We could not, therefore, be assured that all staff had the necessary skills to care for people effectively.

Staff told us that they completed, "lots of training." This had included safeguarding and assisting and moving. Records we looked at showed that senior care workers completed additional training, such as Medicines Officer training which had included the auditing of medicines administration charts (MAR), scenarios in relation to medicines errors and changes in people's needs. Further training was also completed on the impact of failing to administer medicines correctly.

Staff were supported by way of themed group and individual supervisions. We saw that one themed group supervision on 7 June 2016 had covered medicines administration. There were no detailed notes of the discussions that had taken place although the outcomes from the meeting had clearly stated that when any changes to a person's condition had been noted these must be raised with the management.

We saw that staff also had regular individual supervision meetings with their manager. However, again, the records of these meetings we looked at did not evidence what had been covered in the discussions that had taken place.

Records indicated that people were supported to maintain their health and well-being. The daily notes in

one record showed that the NHS 111 had been consulted about a person's deteriorating cough by a care worker and a GP had visited the person.

Requires Improvement

Is the service caring?

Our findings

People had mixed opinions as to the attitude of staff although everybody who had regular care workers were happy with them. One person said, "I think I'm quite lucky that I only really see my regular two or three carers and they couldn't be more polite and respectful. They never mind doing any extra things, like if I'm running out of milk or bread, they will bring me some in the next time I see them. It's the little things like that that make all the difference." A relative told us, "[Name], is my [relative]'s main carer and she comes to help [them] with a shower and hair wash and then just some general housework for us during the week days. She couldn't be more professional and has such a lovely caring attitude that she really brightens the day and we would be at a loss without her."

However, another person told us, "If we're talking about the main body of carers who I see a lot of, because I haven't got regular carers at present, then I think they vary drastically. Some of them are extremely good and will go out of their way to help you, but others make you wonder exactly why they are doing this type of job, because, to be honest, they just want to get done as quickly as possible with as little conversation as possible and just get out of here and on to the next client. Some carers really make you feel like a number rather than a person unfortunately." A third person said, "I sometimes need a hand to get things like fresh linen out of the airing cupboard, or a bit of tidying up done in the kitchen and my regular carer doesn't mind at all when I ask her to do that. When I see other carers though, I am sometimes made to feel extremely guilty for daring to ask them to do anything that's not written down that they're supposed to do."

We have concluded that care workers were caring toward people that they had built a relationship with but did not always show the same attitude to people that they did not know.

Some staff had built excellent relationships with the people that they supported and their families. One person described their regular care worker as, "magic." They went on to say, "[Name] my helper, is pretty genuine although she is pretty strict from time to time." A relative told us, "My [relative] has one particular carer called [Name] who is just wonderful. They get on so well together and he always cheers my [relative] up if [they're] feeling a bit down. Nothing is too much trouble for him and he's almost become a member of the family over the time that he's been caring for my [relative]."

Inadequate

Is the service responsive?

Our findings

We saw that before people started with the service an initial assessment of their needs had been completed and care plans had been developed from these assessments. However, we found that care plans did not always address all areas of identified needs and were not always reviewed as people's needs changed. One person's care plans had been completed 27/07/2016 and referred to the person having mobility and walking around. However the local authority had advised CQC that the person was receiving palliative care in bed and had a syringe driver for pain relief. When we brought this to the attention of a senior care worker they made immediate arrangements for the care plans to be reviewed and we saw the revised plans. Although these reflected the person's current needs we found that they were not sufficiently detailed or personalised. One care plan referred to the person using incontinence pads but no details were included about what pads were used, how often they should be changed or of how they should be disposed. The instructions within the plan which stated "Pads to be disposed of correctly and in the right bin" were insufficient. These did not give guidance to staff as to the correct way to dispose of the pad or which was the right bin.

We reviewed 12 care plan records and found evidence that not all changes had been recorded on the care plans in a timely way. For example, one care record stated the person had three care visits on a daily basis but when we compared this with the call logs from the system, we found that they were visited four times a day. We saw that an increase in their care visits had been authorised by the local authority and had come into effect on 22 September 2016 but a review of their care
plan had not been completed. There was no information in the care records about the support that this person needed during the additional care visit. Another care record completed in March 2016 indicated that a person was to be assisted with transfer from their bed to an armchair in the morning and assisted back to bed after lunch. In September 2016 the local authority reviewed the person's needs and the person required all of their care in bed. The care plans had not been updated to reflect this. Another care record showed that a person was supported on social visits for three hours a week. This had ceased in April 2016 following a review by the local authority. Another person who self- administered insulin had not had their care plan reviewed following a loss of vision, leaving them in need of assistance to prepare the dose of insulin to be administered by epipen. This had led to staff offering support they were not trained to give and a potentially fatal overdose of insulin being prepared by staff.

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

People were aware that there was a complaints system but where they had used this they were not always satisfied with the response that they had received. One person told us, "Yes, I have made a number of complaints about the fact that I don't always see regular carers and also that the timing of my visits can be really far apart. Nothing has ever been sorted out satisfactorily about it and I am, to be honest, made to feel the guilty party for complaining in the first place. I really don't see why I should be to blame for the fact that they don't have enough carers and they can't organise the work efficiently."

We found that there had been no complaints recorded in the provider's complaints system since December

2015. However, we were aware that people had made complaints since then. The branch manager told us that they had a notebook in which they kept a record of complaints that were received but did not enter these on the provider's complaints system until they had been resolved. They told us that they 'kept track of complaints' by using the notebook but offered no explanation as to why none had been recorded in the provider's system. They had referred to one person as a 'regular complainer' but there was no record of the person having made any complaint.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the second visit to the service's offices the registered manager told us that they were to review all the care records to identify those that needed to be updated. The Director of Quality had arranged training for senior care workers on how to write personalised care plans before the updating of plans started. This training would be undertaken on 17 October 2016 and the review of care plans would then start. The registered manager told us that care records would be reviewed systematically with the records for those people who had been identified as at higher risk, requiring more complex care to be reviewed first.

Inadequate

Is the service well-led?

Our findings

The registered manager was also the provider's regional manager and was not at the service on a daily basis. Following the sudden departure of a newly appointed branch manager, the decision was made to appoint an acting branch manager who had previously taken up the role, but had stepped down after failing to perform in it. It was since this decision was made that an increase in concerns had arisen. The registered manager had oversight of the service but had not been actively involved in the day-to-day management. Because the acting branch manager had not been completing the notifications required by the service, the registered manager and the provider's Director of Quality were unaware of the problems we identified.

Although spot checks, quality monitoring visits and daily log audits had been completed, none of these had identified any of the concerns we had during our inspection. Medicines records were signed off as accurate where there were errors, and call times were also signed off as in line with commissioned care when they were not. A care plan that contained inadequate and confusing guidance to staff about the support a person required with medicines was written by a senior carer but not reviewed and signed off by a manager before being put in place. Quality monitoring had not picked up that care plans were not updated following changes in service user's needs.

The head office carried out quarterly quality monitoring visits. In June 2016 this had identified that the recording of incidents and accidents as well as complaints required action. However, nothing had been done to address this at the time of our inspection. Notifications to CQC had not been sent for some safeguarding matters and were sent a month late for two others.

Quality assurance calls were made to people for their feedback on the service provided but no action was taken to address their comments. One person said, "It would be appreciated if they did listen to my views, but I see no sign of them doing that so far." Other people had asked for female only care workers and regular care workers during the quality assurance call but these records showed that these requests had not been complied with.

Documentation was not sufficiently detailed or filed correctly. For example, we found the records of supervision meetings were not sufficiently detailed to evidence the discussions that had been held. We also found local authority service commissioning documentation for six people in another person's care record. We brought this to the attention of a senior care worker who took the documentation to be filed correctly.

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

On the second day of our inspection we were advised by the Director of Quality that the registered manager would be spending the majority of their time at the service. The service was to have two branch managers, each of whom would be responsible for different geographical areas of the service. Eventually one branch manager, their staff and records were to move to new accommodation in the Bedford area.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC of safeguarding incidents

The enforcement action we took:

issued an urgent Notice of Decision to restrict new packages of care being taken on

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans did not reflect the care provided or that commissioned on people's behalf.

The enforcement action we took:

Issued an urgent Notice of Decision to restrict new care packages being taken on

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely and the risk management process was not always effective.

The enforcement action we took:

Issued an urgent Notice of Decision to restrict new care packages being taken on

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider's complaints system had not been used to record complaints. There was no record of complaints received or action taken to address them. People were unhappy with responses made following complaints.

The enforcement action we took:

issued an urgent Notice of Decision to restrict new care packages from being taken on

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was insufficient oversight of the call monitoring system to manage rotas and ensure that calls were made on time, for the correct length of time and by the correct number of care workers. The quality assurance system failed to identify concerns. When areas for improvement had been identified during provider audits no action was taken to address these.

The enforcement action we took:

Issued an urgent Notice of Decision to restrict further packages of care

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed There was insufficient evidence of staff member's right to work in the UK. References had not been validated. Literacy and numeracy of new staff had not been assessed.

The enforcement action we took:

Issued an urgent notice of decision to restrict new care packages being taken on

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to meet people's needs at all time.

The enforcement action we took:

Issued an urgent Notice of Decision to restrict new care packages being taken on