Lean on Me Community Care Services Ltd

Exeter

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 10 and 11 April 2017. The location manager was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure the location manager would be available for the inspection. It also allowed us to arrange to visit people receiving a service in their own homes.

Exeter – Lean on Me provides personal care to people living in their own homes. At the time of the inspection we were told by the location manager there were 19 people receiving personal care. However, we were informed by the local authority there were 20 people being supported by the service.

The service was last inspected in July 2015 where we rated the service as good with a breach of regulation relating to the completeness of employment files as the service recruited all their staff through the providers' other location in Ealing.

During our inspection it became clear as we commenced visits to people's homes on the first day of the inspection that despite the location manager acknowledging our request to inform people of our inspection on Friday 7 April 2017, people were unaware that we would be visiting. As the inspection continued we also discovered the location manager and the entire staff team had become unavailable after completing some morning visits and cancelling other visits earlier and had ceased carrying out all further personal care visits from around 09.00 with no notice to people expecting a care visit. Some people received up to four visits per day and care provided included assisting with meals, assisting with personal hygiene and helping people to bed. Some people were very vulnerable and living with dementia and others were immobile or nursed in bed.

Therefore, we immediately informed the local authority and worked in partnership with them throughout the day to ensure people would receive the care they needed and were safe that day and moving forwards. The registered manager/provider had also tried to locate the staff and location manager unsuccessfully and had informed the local authority.

Exeter – Lean on Me was managed locally by a location manager with support from a small staff team. The registered manager/provider who was based in London, where they were responsible for another location in Ealing, was in Exeter during our inspection. During this inspection we found the registered manager/provider showed very little knowledge of operations in Exeter. 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.

We were part of an on-going safeguarding process and the registered manager/provider had met with the local authority the previous week to discuss a complaint received from one person who was now no longer having support from the service. An incident report found in the location office dated 16 March 2017

indicated that although this had been investigated by the location manager they had not taken any action to ensure care workers were able to identify a medical emergency and support the person to ensure they were safe. They had also failed to respect the wishes of the family. During the meeting the local authority said the registered manager/provider did not have any previous knowledge of the complaint.

The registered manager/provider had made the decision during that meeting to give 28 days notice and cease providing a service by Exeter – Lean on Me by 4 May 2017. They were planning to meet with the location manager and staff on the first day of our inspection to inform them of their decision but on 10 April 2017 also discovered the location manager and staff team had become unreachable. They were unable to provide us with up to date client lists or staff team names as they could not access the location office or office computer without the location manager until the second day of our inspection. They remained unable to access the office computer. This meant they did not show clear oversight of operations at the location in Exeter to ensure there were safe contingency plans and good governance so people were safe.

We were unable to speak with the location manager or any of the staff team during our inspection. Therefore, we could not ascertain the majority of information we needed during the inspection such as the culture of the service, management arrangements and quality assurance, safeguarding, staff rotas, staff training, support and competency and medicines management.

People raised concerns when we visited them as some people had had a telephone call from the location manager on 10 April 2017 giving them very short notice that a care worker would not be visiting them that morning. People did not feel safe and some vulnerable people had had to try to look after themselves or rely on family members or carers and did not know when a care worker would be visiting again.

People also said they did not receive a staff rota so they did not know who would be visiting them to provide care. Although this was mostly the same care worker, they said there had recently received visits from care workers they did not know. People also raised concerns about why they had been asked by the location manager recently to call some care workers by a different name. These care workers were now signing the daily records with that different name. We were unable to discuss this with the location manager and the registered manager/provider could not offer any explanation for this.

There were also concerns raised about limited English language skills and 'people skills' of some care workers. There were occasions when care workers were late due to the workforce travelling by foot or by public transport. The local authority discovered that one person had had two episodes where they had not received care in the previous two weeks. This person was very vulnerable. People were also worried that care workers had not had a day off for long periods. Two people said this had been since October 2016 for some care workers. This indicated there were not sufficient or competent staff at the service to provide consistent, safe care and support for people.

The local authority also carried out reviews for each person as part of the safeguarding process and then to also ensure people were safe when staff became unreachable. Two people and the local authority informed us of concerns about a health and safety issue relating to one care worker. We were unable to view any health and safety risk assessments or discuss this with the location manager as they were unobtainable and the registered manager/provider did not know.

We looked at 26 employment files out of a large number of files held in the office which, although the paperwork looked complete, we could not match the files with the current staff list or meet any staff in person. The location manager had provided a staff list showing nine names including themselves. We were aware that one care worker had recently stopped working at the service. During the inspection we saw

signatures of seven other care workers' names in daily records who were not included on the staff list. We saw two files which could have matched with those names but did not see files relating to five care workers, although they could have been using different names. However, we could not confirm whether these files were kept or why care workers were using different names as the location manager was unobtainable and the registered manager/ provider did not know who was currently working for their service in Exeter. There was a large number of recruitment files kept at the location office and we could not look at them all. We also could not ascertain which staff were currently providing care to vulnerable people. This also indicated that the provider did not have quality assurance checks in place to be assured the location manager was running an effective and safe service which put people at risk.

Care records, however, appeared person centred and detailed how people liked to receive their care. People did not raise concerns directly about the personal care they received. Some people praised the care workers and clearly enjoyed their visits. Some care workers had been working with people for a long time and they were happy with the care provided albeit the concerns raised above. However, we looked at all the care files for each person receiving a service. Care plans, risk assessments and manual handling risk assessments were included but there was varied consistency and many had not been updated or formally reviewed for some time. We could not be sure that staff monitored people's healthcare needs and, where changes in needs were identified, adjusted care to make sure people continued to receive care which met their needs and supported their independence.

The local authority during their reviews also found discrepancies with requests for some people to increase their care from the location manager in relation to people's actual care needs. Local authority reviews did not always match with the needs highlighted by the service. Some people did not require the level of care requested and at least two people's deterioration in health needs had not been highlighted to ensure they were receiving care which met their current needs. We were unable to discuss this with the location manager and the registered manager/provider did not know. However, they told us of an recent incident where information relating to one person's needs had not been included in the care plan. This also indicated the provider did not have quality assurance checks in place to be assured the location manager was running an effective and safe service, again putting people at risk of not having their needs met.

We could not discuss with staff whether they had a clear understanding of the Mental Capacity Act 2005 and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. We could not ask whether staff were aware of when someone may need to receive a mental capacity assessment and who to report this to.

We were unable to discuss what systems the location manager and registered manager/provider had in place to monitor the quality of the service and plan on-going improvements. We saw there was an annual quality service questionnaire which was on-going through 2016. People commented positively about care such as, "My carer is good, nothing too much for her", "My carer is here for me", "They make me feel better" and "He [care worker] works hard and is friendly." However, negative comments did not appear to have been addressed such as, "I don't like going to bed so early", "They [care workers] could improve basic cooking skills", "[Staff] could do with food preparation training, had to be shown how to make a sandwich", "They [staff] are on time if the bus is on time" and "[Staff are] on time apart from Sunday due to buses." We were unable to discuss this with the location manager as they were unobtainable and the registered manager/provider did not know.

The registered manager/provider did not demonstrate any knowledge of the importance of effective quality monitoring. They did not appear to have visited the service for some time or carried out any formal quality monitoring other than telephone calls with the location manager. With the location manager and staff team

absence they did not know any details of the service being provided in Exeter. The systems in place did not enable robust monitoring of the service provided for people to ensure safe, effective, responsive, caring and well led care.

The overall rating for this service is 'Inadequate'. We found six breaches of regulation relating to staffing, fit and proper persons employed, safe care and treatment, need for consent, person centred care and good governance. During this inspection all current people receiving a service from Exeter – Lean on Me were assisted by the local authority to access alternative care providers. The service is therefore not operating due to now having no people receiving a service and an absent location manager and staff team. Following the inspection the registered manager/provider told us they had handed back the office premises keys to the landlord and did not intend to provide a regulated activity from the location in the future. An application has now been received from the provider to remove the location from the provider's registration.

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.

People were not protected from the risk of abuse as we could not be sure current working staff were competent or had been trained to recognise and report abuse.

People were not protected from being looked after by unsuitable staff because we could not confirm the current working staff team or robustly check staff employment files to ensure safe recruitment processes were followed.

Risk assessments were not robust or up to date to ensure people were looked after safely and staff were protected from harm in the work place.

Is the service effective?

Inadequate

The service was not effective.

We could not be sure people received consistent care from a staff team who had the skills and knowledge to meet their needs.

We could not be sure people were always asked for their consent before care was given.

Staff did not always identify or liaise with other professionals to make sure people's healthcare needs were met.

Is the service caring?

Inadequate

The service was not caring.

People could not rely on the staff team to ensure their needs were met in a caring way.

People did not benefit from a service which demonstrated a strong and visible person centred culture.

People were supported by a small team of staff who they were able to build caring relationships with but this was inconsistent and irregular.

We could not be sure people were involved in decisions about their care and support.

Is the service responsive?

Inadequate

The service was not responsive.

Staff did not support people to ensure they received responsive care and support in accordance with their needs and preferences.

Care plans had not been regularly reviewed to ensure they reflected people's current needs and identified changes in need which were actioned appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager/provider and location manager and staff team were not committed to providing people with a high quality service and ceased providing care at short notice without a clear contingency plan to ensure people were safe.

People did not benefit from a service that was continuously finding ways to improve and by actively involving people in how it was run.

There were no robust systems to actively monitor care for people and improve the quality of the service.

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Detailed findings

Background to this inspection

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

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they planned to make. We looked at the information in the PIR and also looked at other information we held about the service before the inspection visit. This service was last inspected in July 2015 and rated good with a breach of regulation 19 relating to completeness of employment files. At that time the location manager said they would ensure they included employment agency profiles as necessary in the future. Since then, staff were recruited from the provider's service in Ealing.

During the inspection we visited and spoke with nine people in their own homes. We had asked the location manager to gain permission from people in advance but this did not happen. Therefore, we ensured people were happy to speak with us at the time of our visit. For some people receiving care we did not disturb them but spoke to six relatives in person or over the telephone. We also spoke to one person's neighbour. Throughout our first day of inspection, when it became clear that the service had abruptly ceased providing care, we worked closely with the local authority and people's family members where appropriate to ensure each person receiving care from Exeter – Lean on Me was safe and could access future care. This included ensuring the local authority were able to follow up any people who we could not access at home or were unable or not answering their telephone.

We were unable to speak with the location manager or any of the care staff team as they had ceased providing care from around 0900 on 10 April 2017 and were unobtainable and remain so. We were able to speak with the registered manager/provider at the location office on the second day. They had been in Exeter to attend a safeguarding meeting with the local authority who shared information with us. The registered manager/provider was unable to access the location office in the absence of the location manager on the first day of our inspection. We met them at the office on the second day when the premises

key holder was available. The registered manager/provider was unable to tell us the whereabouts of any documents relating to the service or access the office computer as they did not know the password. Therefore, we could not access any current staff or client lists other than those supplied by the location manager. These were incomplete.

We looked at the documentation we could find at the office. This included documentation relating to all 20 people who used the service, 26 staff recruitment and training records and two incident reports and the 2016 quality service survey. We were unable to ascertain from the registered manager/provider if there were any other records relating to the service.

Inadequate

Is the service safe?

Our findings

During this inspection we found people were placed at risk because the provider had failed to ensure people received the care they needed to keep them safe. We found the provider's recruitment process had failed to ensure people were free from risk of receiving care from unsuitable staff. The provider had failed to ensure people records relating to risk, were appropriately assessed and managed. People also told us they did not feel safe.

Some people had received an early visit between 06.00 and 09.00 on 10 April 2017. The remaining people had received a call from the location manager between 06.00 and 07.00 on 10 April 2017 informing them their care worker would not be attending their morning visit. No alternative arrangements were made by the agency to provider care to people. They told us the location manager had said they would let them know about further visits. We later found that this was the last communication from the location manager. Therefore, very vulnerable people were put at immediate risk of not receiving personal care, support, medication and nutrition.

Daily records and people and/or their relatives told us they usually had a regular care worker. However, recently the location manager had visited or called them to ask them not to call the care worker by the name people knew but to refer to them by a different name. People were not given any reason for this. From the daily records we looked at, we saw all daily records had been removed from people's homes up until 1 April 2017. When we looked in the office we saw the previous daily records showing the differing names as signed by the care workers prior to 1 April 2017. The registered manager/provider was unable to offer any explanation.

People and their relatives/neighbour told us they could not be sure who would be visiting them to assist with their personal care. Although, they said they generally had the same care worker, recently new care workers (not listed on the current staff list provided to us by the location manager) had been visiting and had signed the daily records.

People did not feel there were sufficient staff numbers to meet their needs in a consistent way. People raised concerns that sometimes care workers appeared rushed. One relative said, "They are in and out like a greyhound". People were also concerned that care workers all travelled by foot or public transport and either asked to stay in their home to wait until the next visit was due or rushed off to catch a bus. This was reported, to us in person and within the recent quality service questionnaire as a particular problem on Sundays. One person said the location manager sometimes gave care workers a lift to their visits and a relative told us this had happened on 10 April 2017 before the subsequent visits ceased. Another person said they had had a call last week from a care worker who could not locate their house and so had had to miss the visit, which the location manager had not covered. This meant this person had not received the care they needed that day. The local authority during their reviews relating to a recent complaint, had found that a very vulnerable person with profound disabilities, limiting communication had not received a visit twice in the fortnight previously.

The registered manager/provider was unable to assure us they regularly reviewed the service and its projected staffing needs. They had no knowledge of the current staff team or client list. They did not know which person received what kind of care package or when. When the care visits abruptly ceased, they had to rely on the information we had received from the location manager prior to the inspection and local authority knowledge and could not ensure people were safe.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18 (1) (2) (a) Staffing.

Risks of abuse to people were not minimised because we could not be sure all new staff were thoroughly checked to make sure they were suitable to work for the service. For example, seeking references from previous employers and carrying out checks with the Disclosure and Barring Service (DBS.) The DBS checks people's criminal history and their suitability to work with vulnerable people. We did not know the current staff list as names in daily records did not appear to match employment files or the staff list provided by the location manager and we could not be sure of the names care workers were using. People had told us recently some new care workers had been arriving and we had seen signatures for at least five care workers that we could not locate employment files for. We were unable to ask the location manager about this. One incident file included 'another care worker' un-named so we could not follow up on the action taken related to that incident.

Risk assessments and manual handling risk assessments had been completed for the 20 people receiving a service. These were a tick box format, giving a score of risk. For example, one person's risk assessment had a tick under 'needs regular steadying and assistance with personal care". Staff were instructed to manage "all aspects of personal care, reassure and promote social interaction". The risk assessment identified the risk as the person lived with dementia and was at risk of unintentional neglect, disorientation and isolation but did not relate to their mobility or unsteadiness risk. Most risk assessments did not have the scoring aspect completed and the assessment did not relate to the 'free hand' comment at the end of the risk assessment. A score of 1 or more indicated a moving and handling assessment was required. This person's was blank.

There were also no reference points as to what was being scored. For example, tick boxes were under broad headings such as assisting, supporting and handling, aggressive/offensive behaviour, external environmental, household hazards and electrical appliances. Most of the risk assessments stated 'no problems identified'. Therefore, it was not clear as to what lighting was in place or details of the person's actual situation and environment. Ten risk assessments and manual handling risk assessments had not been updated since 2014 or 2015. One risk and manual handling assessment had not been updated since September 2012. We saw some evidence that six of these people had received 'spot check' calls or visits but all documentation stated care was the same. For two people, the local authority during their reviews at the time of our inspection found the people's care needs and risk of neglect had deteriorated and therefore was not the same as the care plan suggested.

We were told by two people about an issue relating to the health and safety of one care worker whilst providing personal care visits. We could not find any health and safety risk assessments in the office and we could not confirm who this care worker was.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 19 (1) (2) Fit and proper persons employed.

Inadequate

Is the service effective?

Our findings

The provider had failed to ensure people received effective care and support from staff who had the skills and knowledge to meet their needs. This was because the service was ceased abruptly with very short notice to people on the morning of 10 April 2017. The location manager and staff team did not inform the registered manager/provider or the local authority. People told us they had previously enjoyed the visits from their care workers and their personal care was generally satisfactory. People said, "They [staff] are very thorough", "They [staff] get on with their job" and "The [location manager] is very professional when she covers". However, within the recent 2016 quality service survey carried out by the location manager, we could see some themes of concern arising and people told us about areas they felt troubled by. For example, people had raised concerns about the level of care worker's knowledge of food preparation such as not knowing how to make a sandwich, relating this to cultural differences . Another relative said they often visited the person's home to find them eating a meal straight from a microwave container despite asking staff to put it nicely on a plate. People also said sometimes aspects of care were not completed such as ensuring the person was changed into day clothes from their night clothes or ensuring the curtains were pulled back during the day. The registered manager/provider did not know the detail of the survey results.

As we could not be sure the employment files related to staff currently working we could not ascertain whether staff were sufficiently trained or competent in their role. One incident report dated June 2016 showed a care worker had treated one person with 'sugar water' for a bowel issue. Paramedics had subsequently asked this to be stopped. This showed care workers may not be following safe processes when a health need was identified. The incident report recorded the care worker had received additional training but we could not see what this was. Their staff training matrix showed no additional training between April or October 2016.

Evidence indicated that some new staff may have been working alone without employment or training files completed. We were not able to interview any staff or the location manager to discuss training. We did see some training records indicating some staff had received training up until 2016. A staff training matrix we found in the office showed a comprehensive list of training for one staff confirmed as currently working from the staff list, given to us by the location manager. The training included manual handling, safeguarding, basic life support and infection control. There was evidence in the office of training materials such as a hospital bed and resuscitation dummy. However, we could not discuss training with the location manager or staff. The January 2017 staff training matrix we found did not include at least four staff names we saw signatures of in people's homes. The registered manager/provider was unable to provide this information or confirm a current staff list. Therefore, we cannot be sure what the level of training was for each care worker currently working.

We also could not ask any new staff about their induction experiences as we did not know which staff were new staff. However, people told us new care workers had recently been visiting them whom they had never met before.

We could not access any staff supervision records and the registered manager/provider was unable to assist

with this information. Therefore, we could not be sure that staff were receiving regular competency checks or individual support.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 19 (1) (2) Fit and proper persons employed.

We could not discuss with staff whether they had a clear understanding of the Mental Capacity Act 2005 and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. We could not ask whether staff were aware of when someone may need to receive a mental capacity assessment and who to report this to. Some people receiving care were very vulnerable and living with dementia and were unable to tell us whether they were asked for their consent before they received any care. One person was unable to tell us whether they had had a visit or not that day. We could not find their Exeter – Lean on Me file in their home. The person was wandering around their home which was untidy and they were disorientated eating cold fish and chips with cups of cold tea around the house. We informed the local authority this person was vulnerable and they arranged a social worker visit to ensure they were safe and had access to food and fluids and were receiving an adequate package of care related to their needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who lacked mental capacity to make particular decisions were protected. It is important a service is able to implement the legislation in order to help ensure people's human rights are protected. The registered manager/provider did not demonstrate they understood the principles of the MCA and Court of Protection and their codes of practice and they did not know the needs of current clients receiving a service.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 11 Need for consent.

The registered manager/provider had failed to ensure the location manager monitored people's health or liaised with relevant health care professionals to ensure people received the care and treatment they required. We were told by them about an incident where a care need was not recorded on a person's care plan, which resulted in a complaint by the person's family. They had advised the location manager to include the information on the care plan but we did not see this included. Therefore, we could not be sure that management or staff recorded clear information about any health issues, action taken and the outcome of people's contact with health care professionals.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 Safe care and treatment.

Inadequate

Is the service caring?

Our findings

The provider had failed to ensure people were receiving consistent support from a caring team of staff. On the day of the inspection we found the location manager and staff team had stopped providing care with very short notice to people and their families. Some people had not had any notice and from 09.00 on 10 April 2017, visits had just not happened. This was not caring and placed many people at risk. As the service provision ceased with such short notice and the registered manager/provider had no knowledge of the client or current staff list, this put all the people receiving a service from Exeter – Lean on Me in a vulnerable position where they were highly concerned about how they would manage. They were also distressed about losing their regular care worker, some of whom they had received care from for a number of years.

People said before this date, they generally found the location manager and staff team caring. People and their relatives said care workers were "Lovely girls", "Beautiful girls, I like them all" and "A real joy to work with these carers." Where people preferred male care workers the service appeared to have tried to accommodate this. For example, one person's relative said they had seen the same pair of male care workers for a long time. However, people also raised some concerns about the limited level of English language. One person's carer said they wondered how older people managed with the language and cultural differences. One person's relative said their male care worker usually provided care with no top on as they got hot, which they thought was unusual. Care plans were mostly not reviewed for some time and did not reflect people's involvement although people had signed them initially when the care was commenced. People did not always feel listened to, especially the family who had asked the location manager not to visit their relative in hospital; the location manager had ignored this request and visited the person.

People all said they worried about the care workers as the care workers had shared concerns with them about having no days off, receiving late payments of wages and the lack of staff cover for maternity leave, holiday and sickness. They were also worried about receiving visits from staff they did not know and not having sight of a regular staff rota to know which care workers would be attending. This added to people's worries when they should have been reassured by the service provision.

The registered manager/provider did not know anything about the service being provided and was unable to comment on the care people received.

We were unable to discuss any issues with the location manager or any of the staff team of care workers as they were unobtainable and remain so since our inspection. The registered manager/provider had given notice to the local authority on 7 April 2017 and told us they were trying to ensure the staff team continued providing care during this time but this did not happen.

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

Inadequate

Is the service responsive?

Our findings

The provider had failed to ensure staff and management supported people to receive responsive care and support in accordance with their needs and preferences. Each person had their needs assessed before they started to use the service. This was to make sure the service was appropriate to meet the person's needs and expectations. These assessments gave details about the assistance the person required and how and when they wished to be supported. People told us they were involved in their care and support initially. However, care plans were not reviewed or updated regularly. Some plans contained evidence of spot check visits but these were not consistent. This meant people's needs were not always being reviewed to ensure the care provided was appropriate

Some people receiving a service were very vulnerable and living with dementia or unable to directly communicate their needs. Staff and management had not always identified when people had increased needs or informed the local authority who commissioned the care, of any changes in need. For example, during our visits we found one person clearly living with self neglect who was only receiving one short visit in the morning. They required personal care when we visited them so we ensured they received a further visit from the local authority that day to ensure their needs were met and their care package reviewed.

Another person had not eaten when we visited in the morning and was very confused. Their care plan stated the care worker was to help them with their breakfast but we could see no evidence of any. We informed the local authority who ensured they also received a visit later that day and that their family were involved. Their care plan had last been reviewed in September 2016 and each review stated, "No changes". This person had originally been in hospital with constipation and urinary retention. There was no mention in the care plan about ensuring this did not happen again or how to monitor or manage this. We also had concerns over their safety as other than possibly not having had a visit that morning with no communication from any staff, their environment did not appear safe.

There was no evidence in the care plans of people living with dementia of any information relating to people's personal history, background or any topics of conversation which would assist the care workers to provide care in a person centred way. For example, we were able to engage with one person and reassure them by using family photographs which they were able to talk about.

There was no robust system in place that ensured prompt action was taken to address changes in people's needs. The recording system did not detail what change was required, action taken, completion date and by whom. Most daily records stated the same wording each day and were not person centred or related to any identified issues. For example, daily records regularly noted, "Assisted with all personal care, settled in armchair, made cup of tea, chatted and left her ok". This was written every day for a week and did not comment on how the person was, any changes in mood, dementia progression or mobility for example.

We noted the complaint received by us and the local authority from one person's family was about the lack of responsiveness in recognising a medical emergency. The care worker and location manager had identified the person was not feeling well and had used their pendant alarm and rung a family member but

had then left the person unattended. This did not show staff and management had identified the person required monitoring and support and put them at high risk. The family arrived in time to call emergency services and the person was supported by family in hospital.

We were unable to discuss any complaints with the location manager and the registered manager/provider was unable to discuss any details. The related incident report gave an account of the events but did not recognise that the person should not have been left unattended. This could have been because the location manager was busy and unable to cover further visits due to the shortage of staff and the nature of their travelling between visits.

Therefore, the service was not responsive and did not provide care or identify changes which met people's needs, putting people at risk.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 Safe care and treatment.

Inadequate

Is the service well-led?

Our findings

The service was not well led and put vulnerable people in their care at high risk. The provider had failed to provide a strong management structure which gave clear lines of responsibility and accountability. It appeared the registered manager/provider had not visited the location in Exeter for some time as they were unaware of the current client or staff list. They said they regularly rang the location manager but there was no evidence of their oversight. Therefore, we could not confirm who was actually receiving a service and by which care worker on the day the care visits abruptly ceased. We were unable to have any access to any staff rotas to show which staff visited whom. This put vulnerable people at very high risk and we had to work urgently and in partnership with the local authority who found alternative providers of care to ensure people's needs could be met immediately and for the future.

Although the registered manager/provider was legally responsible for the service, they had no contingency plan and they did not know how the service in Exeter was managed or operated. This demonstrated the provider failed to have a robust method of monitoring the staff and the service to be assured people receiving their service were having their needs met safely, effectively, in a caring and responsive way. At the time of our inspection people were placed at high risk and the registered manager/provider had no information which could assist.

Following the safeguarding meeting with the local authority on 7 April 2017, the registered manager/provider had informed the local authority they would be closing their service in Exeter with the required 28 days notice, ending on 4 May 2017. On the first day of our inspection the registered manager/provider tried to visit the location office and said they were intending to inform the location manager and the staff of their decision. This meeting did not happen as from around 09.00 it became clear the location manager and the entire staff team had become unobtainable and were no longer providing care. The registered manager/provider was unable to access the location office on 10 April 2017 as the location manager had the key.

On the second day of our inspection, once we were assured all the people receiving a service had been accounted for and alternative care packages arranged by the local authority as an emergency, the registered manager/provider was able to use the premises master key. Although the registered manager/provider was present during the second day in the office they could not gain access to the office computer as they did not have the password and they did not know any details about the service provided in Exeter. Therefore, we were unable to speak to any managers or staff who could assist with our inspection or enable us to access any relevant files, other than those we could find in the office. Therefore, there was significant lacking in organisation and leadership in relation to the Exeter location of Lean on Me.

Other than the abrupt cessation and withdrawal of care provision on the day of the inspection there were many on-going failings. There were failings in ensuring robust systems for monitoring the quality of the service provided. For example,we could not see any care plan audits to ensure people's care was regularly reviewed, which they were not. Evidence showed a lack of understanding in identifying and acting on changes in health and personal care needs and liasing with the appropriate agencies, which was also

confirmed during local authority reviews.

The provider failed to have a system that ensured appropriate and suitable staff were employed and appropriately trained. As there was no clear list of current working staff we could not be sure people were safe and receiving care from suitably trained, competent staff who had been employed following robust recruitment and induction processes. We could not be sure which staff files related to current working staff as the staff list provided by the location manager did not include a number of names seen as signed on daily records in people's homes. We also could not be sure current staff were receiving regular supervision and support. Supervisions and spot checks are an opportunity for staff to spend time with a senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed, which we saw had not been. We were not able to access any records of these other than random 'spot checks' in people's care files showing no changes, despite some people requiring changes in care provision.

The provider had failed to ensure their service provided person centred care. People could not be sure they would receive care when they wanted it or in the way they wanted it as there were no systems to ensure person centred care. People could not be sure which care workers would be visiting on a day to day basis and people had met new care workers they did not know or been informed about. People did not receive consistent care from a service which could effectively provide consistent care to cover staff maternity leave, holidays and sickness. This resulted in people becoming worried about the welfare of care workers themselves, including how they were treated by management. There was also an issue with all staff delivering care on foot and using public transport which resulted in anxiety and uncertainty for people as to when a care worker would arrive. When the care provision ceased people tried to call the location manager without success. Another phone number of a care co-ordinator was on people's Exeter – Lean on Me files in their homes, but the registered manager/provider told us this person had not worked for the agency for some time. Therefore, without the contact details of the local authority sent to people on 8 April 2017 detailing that the service had given notice, and our inspection, people would not have been able to access the agency on call service or been supported.

The provider had failed to ensure their complaint's processes helped the service learn from mistakes and improve. Complaint investigations did not robustly show how the service were striving for improvement and although there had been a quality service survey in 2016, this did not address any negative comments the service were aware of.

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