Community Care North East

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 22, 23, 29, 30 June 2017, 3, 4, 7, 10 and 28 July 2017. The first and last days of inspection were unannounced. Community Care North East is registered with the Commission to provide personal care in people's own homes. The service is provided in County Durham and Gateshead. At the time of inspection the provider was no longer providing the service from their registered address. They had move to a new location and had applied to CQC to change their location address. Their new address was Suite 10, Enterprise House, Spennymoor, County Durham, DL16 6JF.

At the last inspection between November 2016 and January 2017 we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The breaches were:-

Regulation 9 Person-centred care
Regulation 10 Dignity and respect
Regulation 11 Need for consent
Regulation 12 Safe care and treatment
Regulation 15 Safeguarding service users from abuse and improper treatment
Regulation 17 Good governance
Regulation 19 Fit and proper persons employed

We also found at the last inspection the provider was in breach of Care Quality Commission (Registration) Regulations 2009. The breaches were:-

Schedule 1 Registered Manager Condition
Schedule 3 Statement of Purpose
Regulation 18 – Notification of other incidents

We asked the provider to take action to make improvements. During this inspection we found continued breaches of the regulations listed above with the exception of Regulations 10 and 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 18 and Schedule 3 of Care Quality Commission (Registration) Regulations 2009.

There was not a registered manager in post. 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.

People and their relatives we spoke with during the inspection held mixed views on whether or not the service was caring. One person liked the staff who visited them and we observed one person engaged in a conversation with humour with two staff members. Another person described the staff as arriving and doing

what they had to do, and then leaving without caring. Three relatives were frustrated with the service provided and felt they had received all possible excuses for lateness.

The service had identified risks to people but had failed to put in place risks assessments which detail to staff actions they needed to take to mitigate the risks. We found documents used in the service were not always accurate and up to date.

We found the service did not administer people's medicines in a safe manner. There were not appropriate arrangements in place with relatives to ensure people received their medicine. Medicines which were required by people on an 'as and when' basis were not always documented with suitable guidance given to staff.

People and their relatives told us staff do not always arrived on time to deliver care. We found staff did not having travelling time between calls. One staff member told us they had been short staff and covered hours. We found the newly appointed manager was attending a recruitment event at a local college to recruit more staff.

People and their relatives had mixed views about whether or not the service could be described as 'Caring'. However due to the deficits we found in the service the ability of staff to care for people was constrained by a number of factors including the lack of risk assessments, supervision and the need to get from one person's home to another without having in place travel time.

Staff completed online training in their own homes and in their own time. There were no checks in place to confirm that the actual staff member completed the training or had absorbed the re required learning. Staff did not receive regular support through supervision.

The provider had in place an electronic monitoring system. This was a system used to monitor when staff arrived and departed from people's homes. We found this was not being monitored effectively and missed visits had not been identified. The system was not monitored to check if staff spent the required amount of time providing people's care. Calls to people who chose not to have staff use their personal landline were not monitored. This meant there were risks of people's visits being missed and systems to reduce this risk were ineffective.

We found staff references did not include sufficient information to ensure people employed in the service were suitable for their role. Brief comments were written down after a telephone call to the referee which did not fully explore the prospective staff member's fitness to work in the service. Following the inspection the provider told us this was a historical issue and did not reflect current practice.

The provider had introduced a four weekly cycle of spot checks on staff whilst they undertook their duties. Staff were not able to tell us which week they were working to. We found these had not been carried out in line with the provider's plan.

Surveys had been carried out by the provider of people who used the service. In two people's surveys they had said they were satisfied with the outcome of their complaints. The provider was unable to demonstrate what these complaints were and what actions they had taken.

We found new audit systems had recently been introduced into the service by the newly appointed manager. These had been used to monitor the daily care records. However we found staff had written about a person experiencing pain when they had applied a person's topical medicine (a cream applied to the skin).

We found the audit tool did not address the specific details of care given to each person.

During our inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Care Quality Commission (Registration) Regulations 2009. These are listed throughout the report. You can see what action we told the registered provider to take at the back of the full version of the report. Details of any enforcement action taken by CQC will be only be detailed once appeals and representation processes have been completed.

Following our inspection we wrote to the provider with our concerns and asked them to provide us with a remedial action plan. They provided us with explanations and actions with deadlines they intended to take. We visited the service on 28 July 2017 to verify if the actions had been taken. We found some actions had not been completed within the timescales and other actions were in progress.

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 given their medicines in a safe manner.

Staff recruitment was not robustly carried out.

People told us staff did not always arrive on time. The staff rotas failed to allow travel time between calls. We found there was not enough staff employed by the service to meet people's care needs.

We found people's personal risks had not been properly assessed. Risk assessments failed to detail actions staff were required to carry out to keep people safe.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received sufficient support through supervision and appraisal.

Since the last inspection staff had carried out training in their own time and in their own homes. There were no systems in place to check if staff had understood their on-line training.

The service was not compliant with the Mental Capacity Act 2005 and the Mental Capacity Act Code of Practice.

Is the service caring?

Requires Improvement

The service not always caring.

People and their relatives found some staff to be caring whilst other people found their service was not always delivered in a caring manner.

We found the service needed to make improvements to ensure staff were able to provide good levels of care.

Staff were able to describe to us people's needs and what

actions they needed to take to support people.

People were not given copies of rotas so they were unaware of who would be visiting to deliver their care.

Is the service responsive?

Inadequate

The service was not responsive.

The delivery of people's care had not been designed to meet their needs.

Staff were not given the correct guidance to enable them to deliver people's care in a safe manner.

The provider and the manager were unable to provide evidence of complaints mentioned by people in their surveys.

Is the service well-led?

Inadequate

The service was not well led.

Documents held by the service were inaccurate and not contemporaneous.

Systems used in the service to monitor quality were not utilised effectively.

We found the electronic monitoring system used to record when staff entered and left people's homes was not effective.

Community Care North East

Detailed findings

Background to this inspection

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

This inspection took place on 22, 23, 29, 30 June 2017, 3, 4, 7, 10 July 2017 and 28 July 2017. The first and last days of our inspection were unannounced.

The inspection team consisted of two adult social care inspectors. A third adult social care inspector joined the inspection team for the feedback meeting with the provider and the manager.

Before we visited the home we checked the information we held about this location and the service provider, for example we looked at the inspection history, safeguarding notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted professionals involved in caring for people who used the service; including local authority commissioners. Local authority commissioners told us they had concerns about the service and were carrying out monitoring visits.

We did not ask the provider to complete 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 plan to make. We used the opportunity of the inspection to explore the plans for the service with the manager and the provider.

During the inspection we spoke with seven people who used the service and six of their relatives. We reviewed 11 people's care files and visited six people with their permission at their homes. We looked at 13 staff files and checked other records held by the service in the management of the regulated activity. We spoke with 11 staff including the owner director, the manager, two senior carers and seven care staff members

Inadequate

Is the service safe?

Our findings

At our last inspection between November 2016 and January 2017 we found the registered provider was in breach of Regulations 12, 13, 17 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches related to safe care and treatment, safeguarding, recruitment and records relating to incidents. During this inspection we found continued breaches of Regulations 12, and 19.

We found that risk assessments did not address people's personal risks. For instance, a risk assessment was in place for one person who had dementia. The measures put in place were generic and did not address how dementia affected the individual. Another risk assessment was in place for the use of a stair lift. There was no information about how the person transferred onto and off the stair lift or how the risk was managed for the individual. We found seven people's care files risk assessments for falls detailed the same information around how to manage a fall but there was no information about the presenting risk for each individual.

One person was prescribed Warfarin medicine. Warfarin is an anticoagulant medicine and it is important that it is taken exactly as prescribed. Staff told us one person's relative gave their family member their medicine on a Monday to Friday but when we asked for the medication records for the weekend staff then said the relative administered the warfarin throughout the week. This was not mentioned in their care records. There was no risk assessment in place or information about the necessity to ensure the medication was given at the specified doses and signs to look out for if there were issues with the medication. We drew this to the attention of the manager who agreed to review the records. Following the inspection the provider told us no member of staff was administering Warfarin and therefore no risk assessment was required.

We found care plans for people's medicines referred to dosette boxes with no information about the actual medication being given. The provider had medication administration records (MAR) charts in place. Staff were signing the MAR charts to say they had given people their medicines from the dosette boxes. On the same page as the MAR chart the provided had incorporated a substantial list of tablet medication that could be prescribed for anyone. The list did not include topical medicines (prescribed medicines applied to the skin). Staff were required to tick which medicines people were taking and record the dose. These lists were not always filled in.

In one person's file we saw they were due to go into hospital and were required not to take a particular medicine before their admission. We saw a staff member had opened their dosette system for the days prior to their hospital admission and had removed the particular medicine. There was no guidance in place in the person's home in respect of each tablet taken. We could not be assured the staff member had removed the right tablet. We drew this to the attention of the manager who stated the dosette box ought to have returned to the pharmacy for the medicine to be removed.

Care workers should only provide the medicines support that has been agreed and documented in the provider's care plan. We spoke with one relative who described putting a person's medicines on a spoon in yoghurt and the carer then gave the person their medicine. Staff confirmed this had happened. We reviewed

the care records and there was no risk assessment or care plan in place to instruct staff on this arrangement. Staff confirmed to us they had been giving the person the medicines without checking what was on the spoon. We found one person who required a homely remedy; their relative confirmed they had been contacted by a member of staff and the relative had advised them to administer the remedy. We reviewed the care records and there was no risk assessment or care plan in place to instruct staff on this arrangement.

People we visited told us they had experienced missed calls. One relative told us they had to visit their family member if the calls were missed. Another relative told us one carer had called when they were expecting two carers and they had to help the carer with their relative. We asked one person if this meant they became hungry. They told us they were "Independent" and could always get something to eat. We visited one person with diabetes. The person took regular medicines. Staff were required to visit four times per day at regular intervals and provide food and drink. We found on one day staff had not visited for six hours. This had not been picked up by the call monitoring system. On the last day of our inspection the manager told us they had disciplined one member of staff for missing a call. This meant people were put at risk of not receiving the care they needed.

This was continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

People told us staff did not always arrive on time. One relative told us staff had made so many excused for lateness they had become, "Unbelievable." Another relative said, "Excuses, heard them all, can't be late all of the time." We checked staff rotas and found one call finished at the time another call started. This meant staff did not have the time to travel between people's homes. We found that staff did not get paid for their travel time but no action had been taken to check that the staff completed the full allocated time at each person's house before moving on. We saw some visits which had been cut short. One member of staff told us they were able to leave a person's home five minutes early to get to the next call. One staff member told us they were short staffed and had been covering calls. The provider told us part time staff had been working extra hours and full time staff were not required to work excessive hours. We found there was not sufficient staff employed in the service. During our inspection the manager was preparing to attend a local recruitment event at a local college. They told us on the last day of the inspection they had recruited two more staff.

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

We looked at staff recruitment records and saw that checks had been undertaken before staff began working for the service. Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults. However we found one staff member did not have an application form which detailed their knowledge and skills. Following the inspection the provider told us the staff member has since completed an application form.

The provider's application form stated, "Please give the names and addresses of two referees (not relatives) who have given their names to be used and to who Community Care North East may now refer as to your suitability for the post." We found in one person's file an immediate relative who also worked for the provider gave a reference. Other references were recorded on file as having been obtained via telephone. One staff member had written as a telephone reference, "All well, good attitude, trustworthy." We found

these references did not provide a satisfactory account of the staff member's conduct. The provider told us this was no longer their current practice.

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

We reviewed 13 staff files and saw an allegation had been made against a member of staff. The provider told us the member of staff was to be accompanied by another staff member until the matter was resolved with the police. During our inspection we were given information by the manager that the staff member continued to be accompanied as they had not received information from the police to say the matter had been concluded. However, when we reviewed staff rotas we saw that, the member of staff had worked on their own unsupervised. During our inspection we reviewed the current week's rota with the manager. The manager confirmed this had been the case. The provider had failed to safeguard people whilst the matter was investigated.

Staff had been trained in safeguarding. We found the manager understood safeguarding procedures and who they were expected to refer to in the light of concerns being raised.

We reviewed the accidents file and found there had been no accidents since our last inspection.

Inadequate

Is the service effective?

Our findings

At our last inspection between November 2016 and January 2017 we found the registered provider was in breach of Regulations 11, 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches related to people giving their to care, staff have the competency to carry out their role and staff supervision. Whilst we found the registered provider had made some improvements in relation to staff training at this inspection we found continued breaches of Regulations 11 and 18.

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

We found the staff had received training around the use of the MCA but from the application of this in the service it was clear further training was needed. Staff did not understand the requirements of the MCA. No capacity assessments had been completed for any of the people who may lack capacity. None of the records made any mention of how conditions such as dementia impacted people's ability to make decisions or take risks. We saw no records to show that 'best interest' decisions were being made. No information was available to show any checks had been made around arrangements made by relatives about staff locking people in their homes when they left. Staff did not recognise that they would need this information or how this may be a deprivation of liberty or that a deprivation of liberty could occur in the community and this would need to be legally authorised. We raised safeguarding alerts on two people who staff were locking in their own home.

The records did not prompt staff to record whether relatives held enacted lasting power of attorney for care and welfare or were a Court of Protection deputy and therefore could legally make decisions about individual's care and treatment needs.

People who purchased the service independently had contracts in place. However we found no evidence to show people had agreed with their care plan or care packages. We found no evidence in the records to show that people had been involved in the development of the care plans.

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

Since our last inspection some staff had completed training in challenging behaviour, dementia, basic life support and moving and handling awareness. We also found that staff completed the online training in their own homes, in their own time and without being paid for this time. We saw there were no checks in place to confirm that the actual staff member completed the training or any systems for checking their understanding or competency.

During our last inspection we found staff who provided personal care did not have the qualifications, competence, skills and experience to do so safely and measures to mitigate the risk to people using services were not in place. At this inspection we saw from staff files staff had updated their training and had received a range of training. We were concerned to note that for one staff member this training had taken place some months before they had applied for their job. The office staff told us the staff member had been working for the organisation at the time therefore it was unclear if the staff file had been incorrectly created after they commenced work or they were working without any checks being made.

The office staff confirmed that all the information about the staff member from their recruitment to on-going employment, such as training, supervision and appraisal was kept in the files we were reviewing. We found limited evidence to show staff received regular supervision sessions or had an annual appraisal. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. The manager told us they were splitting out the current form for supervision, which combined a spot check with supervision, as they found the content only referred to the spot check. On the last day of our inspection the manager showed us a programme of supervision meetings and appraisals they were developing.

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

In people's care plans we saw staff were required to support people with meal preparation and when required provide support to people to eat and drink. People confirmed staff prepared meals of their choice. One person said, "The carers get what I fancy." Relatives told us staff supported people to eat and drink.

Requires Improvement

Is the service caring?

Our findings

At our last inspection between November 2016 and January 2017 we found the registered provider was in breach of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found no evidence to indicate there were continued breaches of these regulations in "Caring".

People we spoke with had mixed views about the care provided to them. One person told us they liked the carers. Another person said, "They don't think, they just get the job done" and "They just come and they go." A third person told us staff went "Above and beyond" and helped them with their pet. Two relatives told us they had heard all the excuses from staff for being late and did not believe staff could be late that many times. They told us they did not trust the staff.

People told us the staff were respectful towards them and did as they were asked. One person confirmed carers were "Respectful in the house." Another person said, "The carers are fine" and told us about their favourite staff member with whom they got along best. However, one relative told us whilst carers were in their home they were using their mobile phone in their kitchen on a personal call. They found this was unacceptable as they were meant to be caring for their relation at the time.

One person told us the staff supported them to maintain their privacy and dignity whilst they were been transferred to use the toilet and the shower. Another person told us staff helped them retain their dignity whilst showering.

We observed two carers chatting to a person; the conversation indicated they were familiar with the person. Staff spoke about people with fondness. One person told us staff would "Do anything" they asked and helped them out.

In the care plan for one person we saw staff were expected to shop and get bread and milk as required. The staff member had left a note for their relative to say they had poured two pints down the sink as they were out of date and the person did not get a cup of tea. We raised this in our letter of concern to the provider who stated the staff member had now left the service. If staff were required to go and purchase milk this would have taken time away from supporting people with their care and was dependent on the shop having milk in stock. They pointed out to us the person was offered an alternative drink to avoid them becoming dehydrated. The provider agreed to take our concern on board and advise staff on what actions to take in future.

Staff we spoke to were able to tell us about people's needs. Staff were able to describe to us what people needed and what actions they were expected to carry out when they visited people in their own homes.

Staff in the office told us care staff got their rotas each Wednesday for the following week. Staff we spoke to told us they get sometimes got their rotas at the last minute. One person told us they did not receive any

communication about who was visiting them to provide their service. This meant people who allowed staff unseen into their home via an intercom system did not always know who they were letting in. Following the inspection the provider told us people could have a copy of the rota if they wished. Some people had chosen not to have a copy as they received their care from a regular staff group

We found despite people making positive comments about staff, staff were not supported to deliver a caring service. Due to the deficits we found in the service the ability of staff to care for people was constrained by a number of factors including the lack of risk assessments, supervision and the need to get from one person's home to another without having in place travel time.

Inadequate

Is the service responsive?

Our findings

At our last inspection between November 2016 and January 2017 we found the registered provider was in breach of Regulations 9, 12, and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches related to a lack of assessments being carried out, people at risk of receiving unsafe or inappropriate care and a lack of care records.

People told us staff had discussed with their needs. One person told us staff, "Marked down in the book [recorded their visit]" when they had been. We discussed with people and their relatives their needs and went through people's care plans with them in their home. Relatives told us what was correct and incorrect in the care records.

We found that for all bar one of the 11 people's care records we reviewed the care plans detailed the support that people were to receive and the frequency of visits. However these were not always accurate. For instance, in one person's care plans there was a lack of information around the support being provided by a relative. Another relative told us they had cancelled lunchtime and tea time visits. These visits continued to be documented in the care plan whilst the person's daily notes demonstrated no such visits took place. We found one person to be at risk of falls and the actions to be taken if they had a fall were incorrect. In another person's file we found a risk assessment for the use of a bath, the person had a shower wet room.

People's care records were not always complete in terms of information about their age, next of kin and key contact points. Also none mentioned that people would not allow staff to log in or refer to alternative means staff could use to confirm attendance such as the staff member ringing in on their phone and the person confirming they were there. We discussed this with the manager who told us they had plans to update the records.

This was a breach of 17(2) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found one person who was receiving personal care without an assessment of their needs having been carried out. They had reduced mobility and required the use of an alarm pendant in case of falls. We wrote a letter of concern to the provider, they told us the person's care plans and risk assessments would be completed by 21 July 2017. When we visited on 28 July 2017 we found the person's risk assessments had not been completed. At our request these were submitted to us by close of business on the same day.

Another person had medical conditions and staff were aware of their conditions. The person used equipment to help them move around their home. There was no mention of their medical conditions or the equipment they needed to use in their care documents. In another person's record we saw they had a catheter in situ, however there was no explanation as to what staff were expected to do. We drew this person's records to the attention of the manager who agreed the care records did not show what actions were required by staff. This meant the service had not carried out with each person an assessment of their needs and designed care to meet their personal requirements.

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

One person told us they had, "No concerns" and "Had no need to make a complaint." Relatives told us it was sometimes hard to make a complaint as they received visits from people who were related to each other, related to the owner or were in a relationship with each other. The owner told us no one had made a complaint about the service to them. In the provider's complaints procedure we read, "We shall maintain a record of each complaint, including details of the investigations made, the outcome and any action taken in consequence." Two people had responded to a survey about the service to say they had made a complaint and were happy with the outcome. We asked to see the complaint. The owner and the manager were unable to give us details of the complaint and told us it might have been a relative who had made the complaint. We looked at the complaints file and found the complaints had not been documented in line with the provider's complaints procedure.

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

Inadequate

Is the service well-led?

Our findings

At our last inspection between November 2016 and January 2017 we found the registered provider was in breach of Regulations 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was not a registered manager in post. One of the owner's had made an application to CQC to become the registered manager but they had since employed a new manager in the service. The director owner told us they intended to withdraw their application and the new manager confirmed to us they intended to apply to CQC to become the registered manager. The provider had submitted an application to CQC to change their location address from Belgrave House, 110 Station Road, Coxhoe, County Durham DH6 4AT to Suite 10, Enterprise House, Spennymoor, County Durham, DL16 6JF.

The provider had in place an electronic monitoring system. When staff arrived in people's homes staff were required to ring a free phone number from the person's house to indicate they had started their call. At the end of the call they dialled the same number and logged out of a person's home. However some people did not want to do this or did not have landlines yet no consideration was given to how this could be resolved so staff could confirm they had arrived at the service. On the first day of our inspection the director owner was on holiday and told us by phone staff in the office were managing the service. When we arrived at the office at 9.30am on the first day of our inspection there was no one responding. Staff arrived at 10am. We found the office based staff completed care tasks with people from 7am until 10am and so were unable to check if staff had logged in during those key times. During our inspection we asked for information from the monitoring records and observed a staff member going to another computer to log onto the call monitoring system. This showed us that office staff did not routinely check if staff had logged into the system whilst carrying out their visits.

We asked the member of staff responsible for the call monitoring to explain the red, amber, green status on the system. This system was used to track if staff arrived at people's homes on time in order to deliver their care. They told us they did not use that section of the system. On the last day of our inspection we found discrepancies between the amount of time a person was assessed as needing on their calls and the amount of time they received. We asked how the length of calls was monitored; the staff member stated they did know why they would need to check this as they checked the staff member arrived. We explained without monitoring the length of calls people could be charged wrongly. The manager stated sometimes staff stayed longer and the hours balanced out. However they were unable to prove this was the case.

In our letter of concern to the provider following the inspection we raised concerns about the system. The manager told us monitoring systems were in place for mornings, evenings and weekends. In addition to the electronic monitoring, they did and always had done, manual monitoring. They told us manual monitoring consisted of a daily check list which included all calls for that day with each carer identified against each call prior to the day in question. However we found one person whose call had been missed and they told us they had slept in their chair all night. The manager was not aware of this call having been missed. We concluded the system in place for call monitoring was not effective.

The manager confirmed that since coming into post two weeks ago they had found no evidence of audits being in place. They told us they were currently devising a system for monitoring the service. We saw they had begun to implement their monitoring system, however we found this lacked detail and the system had not addressed if there were any concerns about the delivery of care. We found staff had recorded in one person's care records when they applied a person's cream they had "Jumped in pain." The monitoring failed to question the practice and if the person required any action taken to prevent further pain.

The provider had in place a four weekly rota to carry out spot checks. The manager and senior carer were unable to tell us which week they were in during our inspection. We reviewed the spot checks in the file and found they had not been carried out on a four weekly basis. We asked the provider to show us the spot checks in staff files. They were unable to demonstrate to us the checks had been carried out.

The provider had in place a disciplinary policy. We found that one staff member was being disciplined for not attending work. Staff told us other people had covered their calls to people's homes. When we explored this with the office staff we heard how the person had texted the staff member responsible for call monitoring to say they were unwell. The staff member told us they had contacted the owner who had sought cover for their calls, but they could provide no information to show how. We asked the manager how this was seen as a disciplinary matter if the person had contacted the service before their shift was to start and for their investigatory evidence. They could not explain the rationale or provide information about their investigation. The staff member told us they no longer had the phone message which they received so could not provide this evidence. We found that the manager had been in post since 12 June 2017, which would suggest they were not initially involved in the incident or decision making. This meant the provider did not have in place effective systems to manage the regulated activity.

This was a breach of Regulation 17(1) (Good governance) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Since the last inspection the provider told us they had introduced twice weekly contacts with staff to discuss the care needs of the people for whom they were providing personal care. At the time of our inspection we requested the provider forward to us via email the contacts which had been made. The provider sent us electronically some of the contact sheets for March and April 2017. We saw where these had been completed, actions had been listed as having been taken including inserting into the files fact sheet information about people's health conditions. On the last day of the inspection we asked for the updated records of the weekly contacts. We spoke to staff on the same morning; two staff were not familiar with weekly updates. One member of the office staff told us they had not carried out any updates that week or the week before. Staff in the office forwarded us emails to state if they had been notified that people's visits needed to be stopped or re-started.

We found people's care records to be inaccurate. In one person's care plan it stated they needed to use a hoist. The person and staff who visited them confirmed this was not the case. On the last day of our inspection staff provided us with a new care plan which did not mention a hoist. In another person's care records it stated they had a catheter. Their relative told us this had not been the case for a number of weeks. Guidance was also given to staff to explain how a person needs to be supported should they fall. Their relative told us the person would not be able to do what was in their plan and a call needed to be made to the falls team for their assistance. This meant the records held by the service were inaccurate, incomplete and were not contemporaneous.

This was a breach of Regulation 17(2) (Good governance) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

The provider had carried out a survey of people who used the service. All of the responses were very positive. We asked the provider if any further surveys had been carried out with relatives or with professionals. The provider told us they not had carried out any other surveys.