PCT Diamond Care Services Limited

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

Overall summary

The inspection was carried out on 14, 15 and 21 January 2015. Our inspection was unannounced, which meant the provider did not know we were coming. PCT Diamond Care Services Limited is a domiciliary care service. The office is located in central Dartford. PCT Diamond Care Services Limited provides care and support for approximately 121 people who are living in the community. People receiving care and support were younger adults who had physical disabilities, older people, and some people that were living with dementia. Some people had sensory impairments, limited mobility

Summary of findings

and some people received care in bed. PCT Diamond Care Services Limited also provided care and support to 26 people living in extra care accommodation called Emily Court.

PCT Diamond Care Services Limited 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 and associated Regulations about how the service is run.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 came into force on 1 April 2015. They replaced the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We are currently taking action against the provider. We will publish an updated report when the action has been completed.

People told us that they felt safe when the staff were providing their care. People told us that they were dissatisfied with the service because staff missed calls to their homes or arrived late without notice. We found that the practices within the service were not always consistent with people's positive views about their safety.

Staff did not have access to detailed, up to date policies and procedures to enable them to keep people safe from abuse. People were at risk of abuse because staff had not undertaken suitable training in order to recognise and respond to suspected abuse.

There were no accurate up to date records relating to the number of people that received care and support. Some people who received a service did not have their care planned or their needs assessed which meant staff did not have the information they needed to care safely or effectively for them. Risks to people's safety had not been properly managed. Assessments were not in place to manage the risks associated with storage and use of oxygen, catheter care and epilepsy and other risks associated with the care and support of people.

Staff did not always have guidance and procedures to assist them in their work. There was no procedure in place to detail what staff should do in the event of the death of a person. There had been deaths in the extra care accommodation which had not been managed or reported properly.

Accidents and incidents had been recorded. However, there was no evidence to show that the registered manager or the staff had regularly reviewed and monitored or learned lessons from incidents that had occurred. In one instance the staff had not amended the care plan or produced guidance or risk assessments when a person's oxygen had not been switched on.

People told us that staff were often late, some people had complained about missed care visits. On the day of our inspection, one relative rang up to complain that no one had been to provide care and support to their family member. The call was made after 09:00. The person was due to have a care visit at 08:00. The staff member that was scheduled to visit the person was off work and no action had been taken to make sure that alternative staffing arrangements were in place. The registered manager had failed to have a system for monitoring how many people required care or how this care would be provided.

Safe recruitment procedures were not always followed. Staff employment files showed that references and full employment histories had not always been checked to make sure the staff employed were suitable to work with people.

The service did not have appropriate arrangements for the recording and safe administration of medicines. Records relating to medicines administered in the community did not detail what medicines people had received.

Staff had not received effective training, support and supervision. Not all staff employed were listed on the training plan. Therefore it was not possible for the manager to monitor the training needs of the team as a whole and ensure courses were arranged in a timely manner in order to meet people's needs. The training records did not evidence how often staff should update or refresh their training.

Staff had not received regular support, supervision or checks of their competency to carry out their roles.

Summary of findings

25 staff out of 48 staff had attended Mental Capacity Act 2005 (MCA) training. Staff showed a lack of understanding with regards to the MCA. This meant that staff had not been trained to ensure people were supported to make decisions in their best interests and how they should recognise if someone was being restricted unlawfully.

Mental capacity assessments did not always follow the principles of the MCA the assessments had not assumed capacity for each person and the assessments were not decision specific. We did not see any evidence that people or their relatives had been involved in mental capacity assessments.

People were not always given choices when they were supported with their meals. One care plan showed that a person needed to drink two to three litres of fluid each day to ensure that they remained healthy. The fluid intake for this person had not been monitored or recorded; therefore the person was at risk of becoming dehydrated and at risk of further health complications. Staff did not always request medical assistance in a timely manner for people whose health needs had changed.

People told us "They never ask me what I would like for breakfast, just put it in front of me. Sometimes they are so late coming they only have time to give me cereal. When my normal carer is away they sometimes do not come at all" and "If I make a complaint they always make excuses".

People told us, "The carers time is very erratic, especially at the weekend when the bus times alter"; "Wouldn't rate them very highly, pretty poor really".

People told us that the staff did call them by their preferred names but we found it was not always possible to know what people's preferred names were as they had not always been recorded in people's care plans. People's care had not been planned for everyone who was receiving care and support. Where care plans were in place they did not contain personalised information for staff to refer to make sure people received the right care for them.

People and /or their relatives had not been asked to be involved in planning their own care or checking that the staff continued to offer the right care and support. Care plans were not in place in some people's homes which meant staff had no information about these people's needs. Where care plans were in place they had not been regularly reviewed or monitored to make sure they remained relevant or up to date.

We found that records relating to people were not stored safely and securely. Some records were kept in the office in the filing cabinet; others were stored in bags, boxes and suitcases within the offices.

People told us that they had made complaints and had not received a response. One person had made six complaints, which had not been dealt with effectively. Records showed that investigations had taken place for the complaints recorded, however records did not show how this was then fed back to the complainant. There were no letters of apology to complainants and no way of documenting lessons learned from the complaints.

The service had not carried out a survey to request feedback from people for more than 12 months. People that had made contact with the manager to complain about the service they received did not feel that they had been listened to.

People told us "If I complain or make constructive comments, they do not listen or answer my calls" and "I wouldn't rate this service good, I suppose one can't expect too much". One person said "Even after I have made a complaint the manager does not call to see if all is well".

The provider did not have arrangements in place to monitor the quality of the service. Medicines administration records (MAR) at Emily Court had not been checked. This meant that errors had occurred but the registered manager had not identified this shortfall or taken action and this put people at risk of not receiving medicines they were prescribed. The manager had not dealt with complaints and incidents relating to staff in a clear and consistent way. Some staff had been suspended for making errors whilst other staff had made the same mistakes but had been allowed to continue working. Their competency to carry out their role had not been checked.

People had not been asked for their views so these had not been taken into account in the way the service was

Summary of findings

delivered. Staff meetings were held frequently but the minutes did not show how staff had been involved or consulted about the quality of the care or the management of the service.

Records were not accurately maintained. There were gaps in records relating to people and staff. Records relating to incidents were inadequate because they did not always evidence the names of staff involved in the incident and what had been done to prevent the same incidents happening again.

The majority of policies and procedures had not been reviewed and updated since June 2013 to make sure they reflected current research and guidance. Policies and procedures were not fully available to staff working in the community. Therefore, staff were working without proper guidance about the standard of work expected of them or how to manage incidents and care safely.

The provider had not met Care Quality Commissions registration requirements. The provider had not submitted notifications regarding reportable incidents such as safeguarding alerts, deaths and moving premises in a reasonable timescale without prompting by the local authority or CQC.

Staff explained to us how they involved people in their care and support. They detailed that they helped people to choose different clothes to wear and encouraged them to do things for themselves.

Staff had suitable personal protective equipment (PPE). This included gloves, aprons, shoe covers, sleeve covers and antibacterial hand gel.

One person told us, “The care I get from my carers is very good. I am treated with dignity and respect and I wouldn’t change my carers for anything. They are angels and I have had the same ones for 18 months”.

Staff demonstrated respect for people’s dignity. They were discreet in their conversations with one another and with people who were in shared areas of Emily Court.

Staff understood their roles and responsibilities but they did not have access to the organisations policies. The staffing and management structure ensured that staff knew who they were accountable to. The provider had a whistleblowing policy. This included information about how staff should raise concerns and what processes would be followed if they raised an issue about poor practice. Ex staff had informed other agencies including CQC of concerns but not until they had left the employment of the organisation when they were no longer bound by the organisations whistle blowing policy.

Summary of findings

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 had not been protected for the risk of abuse or harm.

Medicines were not safely administered or checked which meant that people were at risk of not receiving their medicines in the correct way.

The registered manager did not follow safe recruitment practices.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received effective training, support and supervision to make sure they worked to the expected standard and provided care that met people's needs.

Mental capacity assessments did not always follow the principles of the Mental Capacity Act 2005.

People did not always receive the correct levels of care and support in relation to keeping healthy and hydrated.

Is the service caring?

Inadequate

The service was not consistently caring.

Some people and their relatives said that staff were kind and caring. Others told us that they were not listened to, or always treated kindly by staff.

People were not involved in planning and reviewing their care.

Confidential records were not always held securely or confidentially.

Is the service responsive?

Inadequate

The service was not responsive.

People's care had not been planned to ensure the staff had the information they needed to provide responsive care. People had not received care that responded to their needs.

People had not contributed to the assessment and planning of their care.

Complaints had not effectively been dealt with. People told us that they had made complaints and had not received a response.

Is the service well-led?

Inadequate

The service was not well-led.

No formal checks had been done to make sure the quality of the care and service were monitored and shortfalls identified. Therefore, action had not been taken to improve the care people received.

Summary of findings

The provider had not sought the views of people, their relatives or the staff in the running of the service.

The records were not accurate or up to date and staff did not have access to the procedures they needed to provide effective or responsive care.

PCT Diamond Care Services Limited

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 was 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.

The inspection took place on the 14 January, 15 January and 21 January 2015, it was unannounced. Our inspection was carried out in response to receiving information of concern from both Kent and Bexley local authorities who held a contract with the provider to provide care for people.

The inspection team consisted of two adult social care inspectors, a pharmacist inspector and an expert by experience who made telephone calls to people who received care and support. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed previous inspection reports and notifications before the inspection. A notification is information about important events which the home is required to send us by law. The previous inspection was carried out on 9 July 2013 at the previous registered location (office) and no concerns were identified.

We spent time speaking with five people who lived at Emily Court. Some people were not able to verbally express their experiences of receiving care and support from PCT Diamond Care Services Limited. We observed staff interactions with people and observed care and support in shared areas at Emily Court. We telephoned nine people to obtain feedback about their experiences of the service. We interviewed five staff and the registered manager. We spoke with six relatives.

We contacted health and social care professionals to obtain feedback about their experience of the service. These professionals included local authority care managers, occupational therapists, commissioners and safeguarding teams.

We looked at records held at the office in Dartford, records held in the care office at Emily Court and looked at records held in people's flats within Emily Court. These included 22 people's personal records, care plans and medicines charts, risk assessments, six weeks of staff rotas from Emily Court, staff schedules (care visit lists for each staff member), 13 staff recruitment records, meeting minutes, policies and procedures.

We asked the registered manager to send additional information between the inspection visit dates including staff training records, staff meeting minutes, lists of relatives contact details, up to date staff lists, lists of people who receive a service and action plans set by the local authorities. The information we requested was not sent to us in a timely manner and therefore we collected this information when we visited the service on 21 January 2015.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe when the staff were providing their care. One person told us that they felt safe when being supported to move and had never had any concerns. One person said "I am bedridden and feel completely safe in the hands of my carers. I have had the same ones all the time". However, we found that the practices within the service were not always consistent with people's positive views about their safety.

Relatives told us, "I feel my mother is in safe hands with the carers but I have my reservations regarding the way the company is run. There does not seem enough staff at times". Several relatives told us they had raised concerns about medicines as they had found tablets on their family member's floor.

People were not protected against the risk of abuse or harm because staff did not have access to a 'Safeguarding procedure that gave them the guidance they needed to identify record or report concerns. The external telephone numbers for the safeguarding team at the local authority were incorrect and out of date.

Staff members told us that they would report concerns as soon as possible directly to the registered manager. Several staff members did not know about the safeguarding policy and did not know how to raise an alert if they were unable to contact the registered manager. Kent County Council had shared with us that they were concerned about safeguarding events that had not been appropriately reported to them by the registered manager. PCT Diamond Care Services Limited had failed to report abuse within a timely manner which had led to people being at risk of further harm. The training information supplied by the service showed that 42% of staff had not completed any safeguarding training. This meant that people were at risk of abuse because staff employed by PCT Diamond Care Services Limited had not been trained to recognise and respond to suspected abuse.

The examples above show that people were not protected against the risk of abuse because staff did not know, had not been trained and did not have guidance to respond appropriately. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010,which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager did not have accurate up to date records relating to the number of people that received care and support. On the14 January 2015, the registered manager told us that 119 people received care and support. This did not match with information that we had been given by the local authorities. On the 21 January 2015, the registered manager told us that 127 people received care and support. People and their relatives had complained that staff had failed to arrive to provide their care.

Risks to people's safety had not been properly managed. Risk assessments were not in place to manage the risks associated with the storage and use of oxygen. One person's plan of care recorded that they required the use of oxygen. Staff were responsible for turning the oxygen on and off when they supported the person to move from one room to another. Risk assessments had not been carried out to identify safe ways of transporting oxygen and no guidance had been given to staff on how to safely work with oxygen. This had led to two incidents were staff had forgotten to turn the oxygen bottle on when providing care and support.

Some people needed support with managing their continence through use of catheters and stomas. Whilst the care plans provided details of people's preferences, there were no risk assessment or guidance in place for staff on how to identify possible risks with regard to catheter care, such as how to deal with catheters that were not draining properly, how to deal with blocked catheters and how to care for the skin area around the entry site of the catheter or stoma. People had suffered harm due to inappropriate care.

Staff did not always have guidance and procedures to assist them in their work. For example, there were policies and guidance on what to do in an emergency such as power cut, flood, medical emergency and adverse weather. There was no procedure in place to inform what staff should do in the event of a death of a person.

Accidents and incidents had been recorded but they had not been reviewed. The registered manager had not used any review to make sure that lessons were learnt and

Inadequate

Is the service safe?

action taken to prevent them reoccurring. Care plans and risk assessments had not been updated following incidents or accidents so staff did not know what care they should provide to prevent them happening again. In one case this had led to the same incident happening twice to the same person which caused anxiety to this person and could have led to a healthcare emergency.

The failure to make sure people were protected against the risk of receiving unsafe or inappropriate care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010,which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff were often late, some people had complained about missed care visits. On the day of our inspection, one relative rang up to complain that no one had been to provide care and support to their family member. The call was made after 09:00. The person was due to have a care visit at 08:00. The staff member that was scheduled to visit the person was off work. The registered manager did not have a system for reviewing people's care needs making sure enough people were employed at all times to provide care. There were no arrangements in place to make sure people received the care they were expecting when staff did not arrive to care for them.

The registered manager failed to provide enough staff at all times to care for people safely. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment procedures were not always followed. The registered manager had failed to always check references or full employment histories to make sure the staff employed were suitable to work with people.

The failure to carry out safe recruitment practices to make sure staff were suitable to work with people was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager did not have appropriate arrangements for the recording, using and safe administration of medicines. Medicine records did not accurately show whether people had taken their medicines or not.

The medicines policies were not accurate, appropriate or being followed by staff. These policies stated 'All drugs are to be administered only by the trained staff-in-charge. Staff without this training were administering medicines. The policy also stated that 'Controlled drugs are checked by a second person who has been trained in the procedure'. Some medicines require additional storage, recording and monitoring legal requirements. These had not been checked by two staff at Emily Court, which is a legal requirement, before they had been given to people.

62.5% of the staff had not been trained to safely manage medicines. Staff who were expected to give medicines which included pain killers through a skin patch or a controlled drug had not been trained to understand what they were giving or how to manage the medicine properly or what the side effects may be.

Medicines administration records (MAR) at Emily Court showed that there had been a high number of errors and incidents. MAR charts showed occasions when staff had failed to sign to say whether people received or took their medicines. This included when people had been prescribed antibiotics and it was unclear whether people had received the full course of medicines at the right times. The 'Medicines error reporting forms' did not always show what action had been taken to address the incidents or to learn from them and errors had continued to occur. One error form dated 18 August 2014 detailed that medicines had not been given. No advice had been sought from a G.P or pharmacist about this. The action taken by the registered manager stated that 'Carers will be monitored closely' but apart from one spot check no other monitoring had taken place to make sure staff were competent to safely give medicines to people. Errors had occurred again since that time.

The failure to ensure there were safe arrangements for the management of medicines meant people were put at risk. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

Staff had access to and used suitable personal protective equipment (PPE). This included gloves, aprons, shoe covers, sleeve covers and antibacterial hand gel. A small stock of this equipment was kept in the care office at Emily court. The staff knew how they should use this equipment to prevent the risk of people acquiring infections.

Inadequate

Is the service effective?

Our findings

People had differing views about how effectively the staff cared for them. They said, "If the staff had more time, they would be able to carry out their duties properly but because of transport difficulties they are always in a rush"; "My carers arrange their holidays so they are not away at the same time, and the one who is left brings someone else with her but tells them what to do". One person told us that they had requested not to have certain staff members provide their care and support however they had not been listened to.

Staff had not received effective training, support and supervision. The registered manager did not have any system to check the staff were trained to carry out their roles and provide appropriate care. The training records did not show how often staff should update or refresh their training.

Staff working at Emily Court were expected to care for people with different and sometimes complex health care needs for which they had not been trained.

The manager told us that new staff worked alongside experienced staff for a minimum period of four weeks and that staff who were new into the care profession shadowed and "doubled up" for a lot longer. We found that this only applied to the staff working in the community, those staff new to working at Emily Court were expected to shadow experienced staff over three days. This had not always happened in practice, which meant that people had received care and support from staff that did not know how to support them properly. One person had received care from two staff who did not know how to support them with their continence aids. This had led to inappropriate care being provided and the person suffered harm which required medical attention.

The provider's supervision policy dated June 2013 stated that staff supervision meetings would take place every six months together with a yearly appraisal. The registered manager told us that staff received a spot check every three months to check their practice. These checks had not happened regularly or for all the staff. Two staff files did contain 'Spot check' forms. We found 6 loose spot check forms that were not filed which sowed these staff had been checked in September 2014. Staff had not always worked to the standard expected by the registered manager and this had led to harm for people who they cared for.

The failure to make sure there were arrangements to appropriately supervise and appraise staff was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

25 out of 48 staff had completed training regarding the Mental Capacity Act 2005(MCA). None of the staff we spoke with were able to describe their responsibilities related to the MCA 2005 or how people's capacity to make different decisions affected how they should be cared for and supported.

People's plans of care included a document called a declaration which was intended to seek people's consent and agreement to their care. We found these had not been signed and people's consent to their care had not been sought in other ways apart from staff offering people day to day choices. One person's care planning declaration had been signed by a relative even though the person had been assessed as having capacity to make their own decisions. This meant that people's rights in relation to consent had not always been respected.

Mental capacity assessments did not always follow the principles of the MCA 2005, the assessments had not assumed capacity for each person and the assessments were not decision specific. People and their relatives had not been involved in capacity assessments. One person's mental capacity assessment stated 'Partial mental capacity, she is able to make some decisions and at other times she is not able to make decisions on her own. Family sometimes help when necessary'. There was no evidence the person or their relatives had contributed to this information.

The failure to obtain people's consent and then act in accordance with that consent in relation to the care they received was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014..

Inadequate

Is the service effective?

People received the care and support they needed at meal times but they were not always given a choice of food. Some people who lived at Emily Court were supported to leave their flats and eat dinner at the onsite restaurant. Other people had support from staff who delivered a dinner from the restaurant to their flat. A relative told us that they had overheard some staff offering people only one meal option at dinner times. The relative had stepped in and told the person that there were other options and helped the person get the meal that they wanted.

People's nutritional needs had usually but not always been included in their plan of care. Most staff knew the support people needed to have enough to eat and drink. When guidance was in place the staff were not always following this One person required a set amount of fluid each day to keep them well. This had been included in their plan of care but the staff had not been checking or recording how much they had. This person had a condition which meant they needed this fluid each day or they were at risk of dehydration which could lead to further health complications.

One person needed support to choose healthy meals and this had been agreed as part of their care. Staff told us that regular staff who worked with the person knew what foods the person could choose from. No care plan or guidance had been communicated to the staff to inform them about what this person needed. Staff who did not know them so well may not have offered them consistent care that effectively met their needs.

The failure to make sure that people received a choice of suitable food to meet their needs was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that dieticians provided advice and information when required and that district nurses regularly visited people who need support with managing their diabetes and other healthcare needs.

Staff told us how they made sure they sought medical help when people became unwell. They explained that if they became concerned about a person they would report their concerns to the registered manager and seek medical help when it was needed. Staff told us how they would call the G.P for advice or 999 in an emergency. This had not always happened in practice. Staff told us that the day before our visit one person complained of chest pains, the staff member this had been reported to have not rung for emergency help. The staff member was reminded three times to do this by other staff, when they did make contact an ambulance was called and the person was taken to hospital and was admitted. The local authority informed us about other instances when people had not received the emergency medical help they required.

This failure to have procedures in place to deal with emergency situations was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

People and their relative's views about the quality of the care and the caring attitude of staff varied. One person said, "Wouldn't rate them very highly, pretty poor really". Another person had a very different opinion "The care I get from my carers is very good. I am treated with dignity and respect and I wouldn't change my carers for anything. They are angels and I have had the same ones for 18 months". Another two people told us that they were happy with the staff. However, we found that the practices within the service were not always consistent with some people's positive views about their care.

One relative said, "A carer had spoken sharply to my mother. I didn't like it but didn't say anything". Another relative said that they felt that their family member had been handled roughly by staff when they received personal care. We informed the local authority's safeguarding team about this. One relative told us "Carers are kind but rather loud".

Staff called people by their preferred names because they knew them but their preferences had not been sought or recorded in their care plans. If people received care from staff who did not know them they would not be able to know from the records people's preferred names especially if people were unable to express this for themselves. People's care had not always been planned, and where plans were in place they lacked details the staff would need to care for them in a way they preferred. People told us, "They [staff] think I am not all there but I am OK, there is nothing wrong with my brain" and "They never ask me what I would like for breakfast, just put it in front of me".

People and their relatives had not been involved in planning their own care. Some of the comments above showed that not everyone felt valued or that their views about their care mattered. One of the 22 care plans we saw had been signed by the person or their relative. Care plans were not in place in some people's homes. One person we visited told us that they had moved in to Emily Court in late 2014. They had not been asked what care they would like or need until January after they had complained. Another person's relatives told us, their family member did not have a care plan which met their family member's changing needs until after they had complained to the local authority. People at Emily Court told us that the manager had visited them briefly and asked if they were happy with the care but they had not discussed their care plan in detail.

Staff were discreet in their conversations with one another and with people who were in communal areas of Emily Court. However, they had not maintained one person's dignity when they had recorded that this person always used the call bell and had been told not to as there was nothing wrong with them, when in fact they were very poorly. Staff were careful to protect people's privacy and dignity, they made sure that doors and curtains were closed when personal care was given. Staff told us that they would take care to protect people's dignity if they needed personal care when the person had a visitor by asking the visitor to leave a room while they helped the person. Staff told us that they supported and encouraged people to choose their clothes each day.

These failures to respect and involve people and protect their dignity was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records relating to people's personal details and their care were not stored securely or safely. Some records were kept in the office in the filing cabinet, others were stored in bags, boxes and suitcases within the PCT Diamond Care Services Limited offices. Records at Emily Court were locked in secure cabinets. However, people's records had become mixed up with others as they had not been filed in any order. This meant that people could not be assured that information about them was treated confidentially.

This failure to make sure that records were kept securely and confidentially was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

People had different views related to how responsive the staff were in meeting their needs. One person said, "Sometimes they are so late coming they only have time to give me cereal. When my normal carer is away they sometimes do not come at all" and "If I make a complaint they always make excuses". One person told us "When I complain they put it right".

Relatives told us, "Her [family member] normal carer is good but when she has a relief carer, they often forget to come. When I phone the agency they say someone has been and she must have forgotten. This is not the case because I was here and knew they hadn't been". Another relative told us that staff did not turn up to provide their family member support with personal care at lunchtime on both Christmas day and Boxing Day and had not notified them that they wouldn't be coming. One relative told us that they were in dispute with PCT Diamond Care Services Limited about the calls their family member did or did not receive.

There was a call bell system in place at Emily Court. People told us that sometimes these were not always answered within a reasonable time. People had complained about this. Records showed that over a two week period the call bell had not been answered quickly eight times which had resulted in the call being transferred to a central phone. This meant that people's needs had not always been responded to quickly. We found one message in the staff message book which was from one staff to others. It stated that staff should remind people living at Emily Court not to ring their call bell unless it was an emergency. We spoke to the manager about this. They told us that they had been to see people who lived at Emily Court and told them, "They could use the call bell as much as they liked" and they had spoken to staff about the appropriateness of the message. However in one case a person had suffered harm and required urgent medical attention because the staff had failed to respond to their call bell and provide the care they required.

One relative explained that they had requested additional support for their family member so they could be supported to shower four times a week. The request was made on the 19 January 2015, The registered manager had agreed to additional support to the person to shower each Monday, Wednesday, Friday and Sunday. On Wednesday 21 January 2015, the person had not received extra support and had not been assisted to shower. The care notes confirmed that this care had not been provided. The care plan had not been amended to include the additional support. We checked the care plan in the office and the staff rota schedule and found that the additional support had not been added to the rota, which meant that staff did not know that they needed to provide the additional support to the person.

Some people's care plans detailed their personal history, preferences and interests. These care plans had been transferred to PCT Diamond Care Services Limited from other providers when people had moved between services. The majority of people did not have plans that adequately describe their needs, preferences, routines or how staff should care for them. People who were new to the service had very basic care plans. These contained lists and timetable so they did not describe the staff the individual care people needed and wanted. One person's timetable showed that 'Prepare breakfast/drink' and 'Medication prompt/supervision' had been ticked. It did not detail what the person could do for themselves and what staff needed to do to support the person.

People had not been involved in planning their own care. Relatives told us that their family members care plans were out of date as their family member's needs had changed. People's care plans had not been regularly reviewed and updated.

These failures to ensure people received care which protected their health and welfare and responded to their individual needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager or staff had not sought people's views about their care. The last survey to request feedback from people had taken place over a year ago. People said they had not been consulted or asked about the care or been involved in suggesting improvements to the overall service.

The registered manager had not taken action to check the quality of the service by reviewing this themselves, asking people or their relatives or consulting the staff. They had not recognised that people were receiving a service that

Inadequate

Is the service responsive?

was unsafe, ineffective, unresponsive, and at times uncaring until this was pointed out to them by other agencies. When this had been identified they failed to take action to improve the care people received.

These failures to monitor and asses the quality of the care and service and to listen to people's views were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Complaints had not effectively been dealt with. People that had made contact with the manager to complain about the service they received did not feel that they had been listened to. One person had complained a number of times about the standard of care and the attitude of one staff member. The person had frequently requested not to receive care and support from the staff member, yet the manager continued to send the staff member. This had caused the person to become distressed.

People told us that they had made complaints and had not received a response. One person had made six complaints, which had not been dealt with effectively. Relatives told us they had made complaints about staff leaving their doors open when they left and one relative told us that they had complained about staff not wiping their feet when entering their home, this had made the carpets dirty. PCT Diamond Care Services Limited had offered to pay for the carpet to be cleaned but this had not been done. People told us that when they made complaints about staff the manager had become defensive.

The complaints records did not include any of the complaints people had told us about. The complaints records showed some complaints relating to; lunch care visits being completed just after 09:00, no care visit, staff speaking in their own language when supporting a person and a relative complained that they had not been notified that their family member had been taken to hospital. Records showed that investigations had taken place for the complaints recorded, however it did not show how this was then fed back to the complainant. There were no letters of apology to complainants and no way of documenting lessons learned from the complaints. The investigation notes did not identify who the staff were that had been involved within the complaint and did not identify new systems of work to reduce the risk of similar issues happening again.

The complaints procedure was inaccurate and it did not give people, their relatives or the staff the details or contact numbers they would need to make a complaint outside the provider organisation and when they complained to the provider they had not followed their own procedures.

These failures to identify, receive, handle and respond appropriately to complaints was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

People told us "They are no use in running a company"; "If I complain or make constructive comments, they do not listen or answer my calls" and "I wouldn't rate this service good, I suppose one can't expect too much. However, I can talk to the male boss, man to man". One person said "Even after I have made a complaint the manager does not call to see if all is well".

The provider's website described the aims of the service as 'Our aim is to provide care and support services to our clients that are second to none. The registered manager the provider organisation and the staff were not delivering care in a safe, effective, caring, responsive or well led way. The aims of the provider were not communicated to the staff, consistently, used in practice or monitored for their effectiveness.

The management team at the service included the registered manager and the senior carers. The registered manager told us that they regularly visited people in their own homes and regularly visited Emily Court. No records were available to show how or when these visits had happened or that any action had resulted from them. The registered manager told us that they had not carried out any formal audits. There were no arrangements in place to monitor the quality of the service, identify shortfalls or take action to improve the care or service. The registered manager told us they held the information about people they cared for in their head rather than in easily accessible records. When we asked how many people they provided care for they were unsure and gave different numbers on different occasions.

Medicines administration records (MAR) at Emily Court had not been checked and errors continued to be made without these being identified or rectified which put people at risk of not receiving medicines they were prescribed.

Both Kent and Bexley local authorities met with the provider in December 2014 and January 2015 to set action plans as PCT Diamond Care Service Limited was not meeting standards set out in the terms of their contracts. The action plans showed that the provider had made some minor improvements. The action plans also showed that the provider had not met many of the deadlines set within those action plans. Many action points within the plans were consistent with what we found and showed that the provider was in breach of a number of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Bexley action plan stated 'Develop plan for monitoring service user satisfaction' and 'Check staff training certificates are up to date'. Many of the action points on the plans were systems and processes that should have already been in place as part of an effective system to check the quality of services provided or identify, assess and manage risks to the health, welfare and safety of people. These changes had not taken place.

The manager had not dealt with complaints and incidents relating to staff in a clear and consistent way. Some staff had been suspended from work when they had made medicines errors some staff were not treated equally for the same or similar errors. Incidents had not been recorded accurately and no action had been taken to review accidents and incidents to avoid them happening again... Risk assessments and guidance for staff to follow had not been updated following incidents.

People had not been consulted or their views taken into account in the way the service was delivered. Staff were not involved in sharing ideas or developing and improving the service. Staff had not been supervised to enable them to share any concerns or discuss their standard of work and what was expected of them.

The provider used electronic call monitoring system (ECM) to monitor when staff arrived and left people's homes. The provider was unable to use this to accurately monitor whether the care visits had been made at the right time and whether the staff member had stayed at the person's home for the correct length of time. There were a number of times when no record was available to show that staff had attended a care visit to someone's home. The provider was unable to tell us the reasons for this or whether the person had received the care they needed or not. The provider explained that they had tried to rectify some of the problems with the ECM system and we saw evidence to show they had been in contact with the ECM provider. No alternative arrangements had been made to monitor that staff were carrying out visits and people had told us t that there had been times when no staff had arrived to care for them.

Inadequate

Is the service well-led?

We requested information from the registered manager both during the inspection and on a separate occasion. The registered manager failed to provide the information we had required from them.

These failures to monitor and assess the quality of the care and service and to provide information were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records relating to people's care and the management of the service were not well organised, accurate or adequately maintained. We identified gaps in records or no records in relation to people's care and the management of the service. These related to medicines, staff training and recruitment, care planning, risk assessments, complaints and care plans.

The majority of policies and procedures had not been reviewed and updated since June 2013 to make sure they reflected current research and guidance. Policies and procedures were not fully available for staff who worked in people's homes. There were no hard copy of policies and procedures that staff were able to use guide their work or the care they provided. Staff did not have easy access to the policies and procedures stored on the computer system as they could only be accessed by the registered manager. They told us that they would allow staff to access policies by logging on to the computer and showing staff the relevant documents.

These failures to maintain accurate records or proper information about people's care or the management of the service was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not met Care Quality Commissions registration requirements. The provider had not submitted notifications regarding reportable incidents such as safeguarding alerts, deaths and moving premises in a reasonable timescale without prompting.

This failure to inform the commission about notifiable events was a breach of Regulation 16 and Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

Staff knew they were accountable to the registered manager and they said they would report any concerns to them. The staffing and management structure ensured that staff knew who they were accountable to. Staff meetings were held frequently but staff had not been encouraged to develop their skills or knowledge or to participate in the running of the service.

The provider had a whistleblowing policy. This included information about how staff should raise concerns and what processes would be followed if they raised an issue about poor practice. The policy stated that staff were encouraged to come forward and reassured that they would not experience harassment or victimisation if they did raise concerns. The policy included information about external agencies where staff could raise concerns about poor practice such as the charity, Public Concern at Work. The whistleblowing policy also directed staff to the Care Quality Commission. Ex staff had contacted the Care Quality Commission to raise a concern but as they had left their employment the whistle blowing policy of the provider no longer applied to them. They did not share with us why they felt unable to raise concerns during their employment.