First Class Care Limited

FIRST CLASS CARE

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

Overall summary

This inspection took place on 16 October 2015. First Class Care is a domiciliary care service which provides personal care and support to people in their own home across Nottinghamshire. On the day of our inspection 11 people were using the service. At the time of our inspection First Class Care was operating from an address which was not registered. The provider had not taken the appropriate action to correctly register the location.

The service had not had a registered manager for five months prior to our inspection. The nominated individual had applied to become the registered manager and we have referred to them as 'the manager' in this report. 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.

At our inspection in May 2013 we asked the provider to take action to make improvements in respect of recruitment procedures. During this inspection we found

Summary of findings

that sufficient improvements had not been made. The provider had not carried out all of the required pre-employment checks to assure themselves that staff were suitable to work with vulnerable adults.

There were not enough staff available to meet people's needs in a timely manner. Not all of the necessary steps had been taken to safeguard people from the risk of abuse. Risks to people's health and safety had not been appropriately assessed or managed. People did not always receive their medicines as prescribed and staff had not been provided with accredited training in managing medicines.

Staff had not been provided with the knowledge and skills to care for people effectively. There was no formal supervision process in place for staff. People did not always receive the support they required to have enough to eat and drink.

The Care Quality Commission (CQC) monitors the use of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). There was a lack of knowledge of the MCA and the rights of people who may lack the capacity to make decisions were not upheld. Where people had the capacity they were asked to provide their consent to the care being provided.

People and their relatives were able to be involved in planning their care, however their choices were not always respected. Excessive delays in care being provided meant people's dignity could be compromised. However, people were treated in a respectful manner by staff. People were cared for by staff who had developed caring relationships with them.

People did not always receive the care they required at the agreed time because staff were often early or late. People's care plans had never been reviewed so we could not be sure that staff were providing the care that people needed. Whilst the complaints we saw had been appropriately responded to, we could not be sure that the provider had received all complaints.

At our inspection in May 2013 we asked the provider to take action to make improvements in respect of record keeping. During this inspection we found that sufficient improvements had not been made. Staff did not always complete records accurately and some entries were blank. Records were not securely stored.

People had not been asked for their opinions on how the service was run. There were no systems in place to evaluate and improve the quality of the service. The service did not have effective management and records were not always accurate or stored securely.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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?
The service was not safe.

Although staff had some knowledge about how to keep people safe, the provider had not ensured that all risks to people's health and safety were assessed and managed.

There were insufficient numbers of staff and they were not effectively deployed. Staff had not been appropriately vetted to protect people from unsuitable staff.

People did not always receive their medicines at the correct time or as prescribed.

Inadequate

Is the service effective?
The service was not effective.

People were cared for by staff who had not received training or support through supervision.

People were asked for their consent however the best interests of people who may lack the capacity to make decisions had not been considered.

People were not always supported to eat and drink enough.

Inadequate

Is the service caring?
The service was not always caring.

People were involved in planning their care however their choices were not always respected.

Excessive delays in people receiving their care meant their dignity could be compromised.

People were cared for by staff who had developed positive, caring relationships with them.

Requires improvement

Is the service responsive?
The service was not responsive.

Staff frequently arrived late so people did not receive personalised care. People's care had never been reviewed and so changes had not been made in response to people's needs changing.

Complaints were responded to appropriately although we could not be sure the provider had received all complaints.

Inadequate

Is the service well-led?
The service was not well-led.

Inadequate

Summary of findings

People were not asked for their opinion about the quality of the service. Systems were not in place to evaluate and improve the service.

First Class Care was not correctly registered and did not have adequate leadership.

Records were not accurate and had not always been securely stored.

FIRST CLASS CARE

Detailed findings

Background to this inspection

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

We visited the service on 16 October 2015, this was an announced inspection. We gave 48 hours' notice of the inspection because we needed to be sure that the manager would be in. The inspection team consisted of two inspectors.

Prior to our inspection we reviewed information we held about the service. This included information received and statutory notifications. A notification is information about important events which the provider is required to send us by law.

During our inspection we spoke with five relatives of people using the service, two members of care staff, the manager and a consultant employed by the manager. We looked at the care plans of four people and any associated daily records such as the daily log and medicine administration records. We looked at six staff files as well as a range of records relating to the running of the service such as training certificates.

Inadequate

Is the service safe?

Our findings

At our inspection in May 2013 we found that people were not fully protected from the risks associated with unsuitable staff because recruitment procedures were not operated effectively. The provider submitted an action plan detailing the improvements they planned to make. During this inspection we found the required improvements had not been made, this meant people could not be sure staff were suitable to work with people using care services.

Whilst criminal records checks had been carried out, suitable references for conduct in previous employment had not always been requested. Four members of staff had offered each other as a referee. This meant evidence of staff members' conduct when working in a health and social care setting was not available. There were also inconsistencies in the information staff had supplied on their application forms which had not been followed up by the manager during the interview process. We found that one staff member's application and references indicated a recurring disciplinary issue which was not explored further at their interview. This staff member's file showed that the same issue had arisen during their employment with First Class Care. Although the manager had followed disciplinary procedures, the recruitment procedures were not effective in protecting people from inappropriate staff.

The provider had not carried out all of the required pre-employment checks which meant there was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were insufficient staff employed and staff were not deployed effectively. Because the people who used the service were spread out geographically this meant staff often had to travel long distances and at busy times of the day. This resulted in people not receiving the care they needed when planned as staff were regularly late for people's appointments. Although the staff we spoke with did not raise any concerns about this, the manager and their consultant told us they did not have enough staff. Although there were plans in place to recruit more staff so that they could work closer to home and reduce the amount of travelling time, there were insufficient staff at the time of our inspection.

The insufficient staffing levels meant there was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The relatives we spoke with told us they felt their loved ones were safe when staff were providing care in their home. One relative said, "Yes they are definitely (safe), no concerns." Another relative told us that they felt their loved one was safe and that staff ensured their property was secure before they left.

We found the provider had not ensured that the necessary training was provided and the majority of staff had not received any training in understanding their role in protecting people who use care services. Although staff knew about the different types of abuse which could occur and told us they would not hesitate to report anything of concern; appropriate steps had not been taken to ensure people were supported by staff who knew how to keep them safe and the action they may need to take to report concerns.

There was a risk that staff would not know how to ensure individual people's safety or how to react should a person be at risk. The care plans we viewed did not contain information about how to safeguard people who may be at risk of harm or abuse. For example, we were told that some people were living with dementia but their care plans did not contain information about how this affected them. This meant there was a risk staff would not know how to react should a person present behaviour which may be challenging. The staff we spoke with told us they felt able to safely meet people's needs, despite not having information about how to meet people's needs and had no concerns about their safety. However, the lack of information about how to protect people meant staff may not be aware of the necessary steps to take to keep people safe.

The lack of adequate safeguards for people meant there was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The relatives we spoke with told us they were satisfied risks were appropriately managed by care staff. However, risks to people's health and safety had not been assessed and measures were not always put in place to reduce risks. Each person's care file contained risk assessments for their property and for any moving and handling support they

Is the service safe?

required. However, these did not identify risk factors or an overall level of risk. In addition, they did not always identify what steps staff should take to manage the risks when supporting people.

Staff told us they were made aware of different risks to people's health and safety and knew how to manage these. We were told that the manager showed each member of staff how to support people. Not all staff had received accredited training in safe moving and handling techniques. In addition to this, the care plans we looked at did not provide staff with adequate guidance as to how to manage any risks to people, such as the risk of them falling or acquiring a pressure ulcer. For example, one person was reliant on staff to move them, change their position and apply cream to their skin. The risk of their skin breaking down had not been assessed and there wasn't adequate guidance to staff about how to reduce this risk to ensure that the person was protected.

The lack of assessments of the risks to people's health and safety meant there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The relatives we spoke with told us they were satisfied that their loved ones received their medicines as prescribed. However, we saw that people were placed at risk of not receiving their medicines at the correct intervals as we found there were frequent and long delays in people receiving their medicines. The records we viewed showed that staff frequently arrived late and this meant people did not receive their medicines at the correct times. At other times people's calls were very close together because staff had been late arriving at the first call but then arrived on time for the second call. This meant there was not always a sufficient time gap between doses of medicines being administered. For example, there should be gaps of four hours between people receiving certain pain relieving medicines. We saw that there had not always been a gap of four hours between people being given these medicines, which left them at risk of a potential overdose.

People were placed at risk of not receiving medicines which were fully effective as staff did not always follow the prescriber's instructions. One person had been prescribed a course of antibiotics to take over seven days. We looked at this person's medication administration record (MAR) chart which had several gaps and two days where no record had been made. Therefore we could not be sure this person had received their medicine as prescribed. The manager told us the antibiotics had been prescribed to only be given when the person felt ill. However, antibiotics are prescribed to be taken for a defined period of time to treat an infection. Another person received medicine that was to be given only once a week. Their MAR chart showed that staff had either administered or offered the medicine on the wrong day on 15 different occasions over a two and a half month period.

There were also inconsistencies in the information recorded on people's MAR charts. For example, the manager told us that one person had been in hospital for a period of several days and not receiving care. However, staff had still completed the MAR charts to indicate their medicines had been administered. Another person's MAR chart was blank for the first 20 days of September 2015, which the manager explained was because they had not provided a MAR chart in the person's house for staff to complete. Staff had completed the MAR chart between 21 and 25 September but it was then blank for the remainder of the month. The manager was unable to explain why this was the case or what action they had taken. This meant there was a risk that the person had not received any of their medicines at these times which would impact upon their health.

The staff we spoke with told us they had not been provided with training in how to safely administer people's medicines. The manager confirmed that staff had not been provided with accredited training in medicines administration but said they had showed staff how to administer people's medicines. However, the manager was not an accredited trainer so we could not be sure the training was of sufficient quality. People's MAR charts were not checked so the errors in administration and recording had not been acted upon by the manager.

People's medicines were not safely or properly managed meaning there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Whilst the relatives we spoke with were complimentary about staff, they had not received the required training and support in order to provide people with effective care. For example, staff had not received training in meeting people's nutritional needs or supporting people living with dementia. The manager told us that they showed staff how to care for people during their induction. There was no evidence available to show that the manager was competent to train staff and there was no record available to confirm what training staff had received. The staff we spoke with confirmed the manager had shown them how to care for people, but had not received any other training from First Class Care.

There had not been any training provided for a period of seven months. Two members of staff had received a limited amount of training in areas such as medicines administration and moving and handling techniques. However other staff had received no training since starting at First Class Care. The staff we spoke with told us they still felt able to provide the care people needed because the manager had supported them to understand people's needs and they had received training in previous employment. However, people could not be sure staff had the necessary skills and knowledge required to care for them properly.

People were cared for by staff who had not received any formal support through supervision. Whilst the staff we spoke with told us they felt supported by the manager, they confirmed they had not received any supervision. This meant that people could not be sure that the performance of staff was being effectively monitored. The manager told us they carried out periodic visits to people's homes to observe staff practice. However there were no records to confirm this had taken place and whether the manager had taken appropriate action should any concerns arise. The relatives we spoke with were not aware of any such visits taking place.

The lack of support for staff meant there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people may lack the capacity to make a decision the principles of the Mental Capacity Act 2005 (MCA) had not been followed. We could not be sure that the manager and staff were acting in people's best interests. The manager told us that some people were living with dementia and lacked the capacity to make certain important decisions, such as who managed their medicines. However, no assessment of people's capacity to make these decisions had been carried out. The manager told us that in this situation they would act on the instructions of a relative. However, the manager had not ensured that the relatives had the necessary authority to make care related decisions for people and there was therefore a risk that their rights may not be upheld. This also meant that people had not always been supported to make choices about their own care.

Staff had not been provided with any training or development to understand their role in supporting people to make decisions and acting in their best interests. However, the staff we spoke with told us that they supported people to make their own decisions where possible.

The provider had not acted in accordance with the MCA which meant there was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The relatives we spoke with confirmed they and their loved ones had been involved in setting up the care packages and were asked for their consent at this point. Relatives also told us that staff ensured they explained what they were about to do and obtained people's consent before they provided any care. The staff we spoke with also told us about the importance of asking people for their consent before providing any care. People's care plans did not evidence that they had given their consent. There were sections that required people's signature to confirm their consent to the care they received and these were blank. This meant there was a risk that staff were providing care people had not consented to.

Two of the relatives we spoke with told us they were concerned that their loved one did not always receive enough to eat. One relative said, "I don't think staff always know what [my relative] would like to eat." Another relative told us that staff did not always have the time to sit and provide the support their loved one needed to eat well.

We found that there were significant delays in some people receiving the support they needed to eat and drink. A relative told us that, because staff were often very late,

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Is the service effective?

their loved one did not receive meals until one or two hours later than they wanted to. We looked at people's care records and these confirmed that staff routinely arrived very late, which meant people did not receive their meals at the time they wanted. We saw that on several occasions, people received meals too close together because one call had been late and the next call at the correct time.

Staff told us they were made aware of the kind of meals they should prepare for people and that they offered people a choice. They also told us that they had the required information about people's dietary needs and preferences. However, the care plans we viewed contained limited information about people's likes, dislikes and dietary requirements. Furthermore staff were not keeping accurate records about the food and drink people had consumed. One person's care plan instructed staff to record their fluid intake due to their healthcare condition. Whilst staff had recorded the drinks they had offered to the person there was no confirmation of how much they had actually drunk. This meant the person may not have been drinking adequate amounts to maintain good health.

People were not always supported to eat and drink enough which meant there was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

First Class Care was not responsible for arranging access to healthcare services for people. However, we could not be sure that staff had always dealt with any concerns they had about people's health in the appropriate way. Staff had noted that one person had vomited on several occasions but had not recorded what action they had taken until two days later. The manager was able to recall this and told us that staff had contacted them for advice and they had taken action. However, there were no records to verify that this was the case. On other occasions staff had taken appropriate action and made records to confirm the action taken. For example, staff had noted a mark on a person's skin and recorded that they had reported this to their GP.

The staff we spoke with told us they would report any concerns about a person's health to the manager and they felt that the manager would contact the person's family or their GP. Staff knew about various emergency and non-emergency healthcare services that they could contact in different situations.

Requires improvement

Is the service caring?

Our findings

The choices people had made about the time they wished to receive their care had not been respected because staff frequently arrived late. This meant that various decisions people had made, such as when they wished to get up in the morning and go to bed at night, had not been respected.

People and their relatives were involved in planning their own care when they first made contact with First Class Care. One relative said, "Yes at the initial set up everything was well and truly discussed." The other relatives we spoke with told us the manager had met with them and taken information about what care they wanted and their preferred times. Relatives also told us that staff involved people in making day to day decisions, such as what clothes they wanted to wear.

People's care plans contained an initial assessment of their needs which was completed prior to their care package starting. These had been completed with people's involvement and asked people about what was important to them and what care and support they needed. Staff told us they involved people in day to day decisions relating to their care to ensure that these choices were respected. For example, staff respected people's independence should they wish to carry out some of their own personal care.

People's dignity was compromised because of excessive delays in their care being provided. Because some people were reliant on staff to provide their personal care, there was a risk that their personal hygiene may be affected because of the delays in their care being provided. However, the relatives we spoke with told us they felt staff treated people with dignity and respect. One relative said, "I have no concerns, I am sure staff treat [my relative] properly. Another relative told us, "It (the care provided) seems to be respectful and [my relative] has not said anything to me to the contrary."

Staff understood the importance of maintaining people's dignity treating them with respect. Staff displayed a clear understanding of how to provide personal care in a way which protected people's dignity, such as by ensuring people were protecting their modesty when being given personal care. Staff also told us they took their role seriously and they knew it was expected that they would treat people respectfully. People were afforded privacy when they required it. For example, a member of staff told us that they ensured door and curtains were closed before starting to provide personal care. The care records we viewed demonstrated the importance of providing care that was dignified and respected people's privacy.

The relatives we spoke with told us that staff were caring and they had developed positive relationships with their loved ones. One person said, "Now we have consistent staff it is better. The staff are lovely." Another relative told us, "They seem to be (caring) it doesn't seem to be forced in anyway. They do genuinely seem to want to do the best for [my relative]." Another relative commented, "From what I have seen, yes the staff do seem to care."

People were cared for by staff who valued the relationships they had built with people. Staff could describe the different ways people preferred to be cared for and spoke warmly about them. We were told by staff that they enjoyed their work and enjoyed spending time with people. Where possible, the same staff were assigned to care for people so that relationships could be developed over time. Staff told us they appreciated this consistency and found it had helped them build relationships with people. The relatives we spoke with told us there had been recent improvements in the consistency of care staff.

Whilst two relatives told us they felt staff did not always have sufficient time to carry out the tasks required, they acknowledged that staff tried their best. The other relatives felt that staff had sufficient time to provide the care people required. The staff we spoke with told us they did have sufficient time on each call to complete the assigned tasks without having to rush people. Staff also told us they would not rush to complete a call quickly, even if it meant they were late leaving the person's house. The care plans we looked at described people's needs in an individualised way and emphasised the importance of building a relationship with each person.

Inadequate

Is the service responsive?

Our findings

People did not always receive care when they needed it because staff did not always arrive at the allocated time. Two of the relatives we spoke with told us that staff were frequently very late and they did not always know when staff would arrive. They told us that their relative had not received important support such as taking their medicines or being supported to go to bed because of staff being late. The other relatives told us that staff were occasionally late, however this had not caused their loved one any difficulties.

The manager acknowledged that staff did not always arrive at the scheduled time and told us they hoped to be able to recruit more staff in particular geographic areas to try and resolve this issue. People's records showed that staff had arrived up to three hours late on several occasions. There were numerous occasions where care staff had arrived one hour late. For example, the care plan for one person stated they would receive four daily calls covering breakfast, lunch, tea and bedtime. The daily visit record for this person showed that between 17 August 2015 and 11 October 2015 the agreed time slot had been missed 28 times. This included 11 occasions when the staff member was late by over two hours and three occasions when the person's bedtime call was more than an hour early.

People's records contained some gaps where staff had not made an entry and so it appeared they had not received their planned care. For example, there was a two week gap in one person's records where it appeared no calls had been made at all. Another person's records did not contain any information for two of their calls over a six day period. There was also evidence that some calls were made too close together, because one call had been completed late. Staff were not always recording the times they arrived and left so we could not be certain that staff were staying for the required length of time. This meant that people were not receiving care in response to their needs because staff did not always arrive at the correct times. In addition to this, staff may not always have stayed for the full amount of time meaning there was a risk people may not have received all of the care they needed.

People's care plans had never been reviewed so we couldn't be sure that changes were made to their care when required. The relatives we spoke with also told us they were not aware of any care reviews having taken place. This meant people had not been given the opportunity to say if they were happy with their care or if they required any changes to be made. The manager acknowledged that they had not been able to review people's care plans. The care plans we viewed did not contain any evidence of changes having being made, for example when people had been unwell. This meant staff may not have up to date information about people's changing needs.

People did not receive person centred care which meant there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The relatives we spoke with felt they could raise concerns and make a complaint. One relative said, "I have never complained – but wouldn't feel uncomfortable to do so." Another relative told us they had recently made a complaint and this had been responded to positively. They told us that the care their loved one received had improved since making the complaint. The relatives we spoke with were not aware of having received a complaints procedure, but told us they knew how to get hold of the manager over the phone.

We looked at the complaints that had been investigated in the 12 months prior to our inspection. Each complaint had been thoroughly investigated and a response sent to the complainant in a timely manner. The provider offered an acknowledgement and apology where they felt their service had dropped below an acceptable standard.

Inadequate

Is the service well-led?

Our findings

At our inspection in May 2013 we found that people's care records were not always completed fully or accurately by staff. The provider submitted an action plan detailing the improvements they planned to make. During this inspection we found the required improvements had not been made. Staff were expected to complete various records to detail the care they had provided to people. We saw that there were gaps where staff had not made any entry at all. In addition, staff had not always followed the guidance in people's care plans about record keeping. For example, one person's care plan instructed staff to record how much fluid they drank. We saw that staff had not kept accurate records and so did not know if the person was drinking sufficient amounts. Other records such as medicine administration record charts were also not accurately completed. This meant staff could not accurately evidence the care that had been provided to people.

People could not be assured that confidential information about them was safe because records relating to their care were not always securely stored. First Class Care had recently moved to a new office address, however many records were still being stored at the previous address. Neither address was routinely staffed, meaning that records were not secure. In addition, we saw that some staff files had been left in a cabinet which could not be locked. This meant confidential and personal information about staff could be accessed by anybody gaining access to the building.

People's views about the quality of the service were not actively sought and this was confirmed by relatives and the manager. The relatives we spoke with told us they had not been asked for their opinion of the quality of the service. The information pack given to each person on commencement of the service stated they would receive an annual satisfaction survey, quarterly questionnaire and regular contact by telephone. The manager told us that this had not happened. The consultant told us they had just started to contact people with a view to asking for their opinions about the service and had distributed some surveys. However this information had not been analysed or acted upon at the time of our inspection.

Effective risk management systems were not in place nor were systems to develop and improve the service, based on the needs of the people who used it, their families and staff. This resulted in us finding multiple breaches in regulations and negative outcomes for people who used the service. The quality of service people received was not checked and the issues we identified had not been identified or acted upon to ensure that people received quality care that met their needs. For example, no audits were carried out regarding staff practice or record keeping which meant that the problems we identified had been continuing for an extended period of time.

As the manager also provided care to people using the service, this limited the time they had available to perform managerial duties and resulted in a lack of appropriate governance and oversight of the service. For example, the manager told us they carried out spot checks on staff however there were no records to verify this or to confirm any actions taken to improve the service. This meant there was a lack of overall leadership and oversight of the service and issues had not been picked up or acted upon. The manager had recently employed a consultant to try and address issues with the service; however they had not been able to make improvements at the time of our inspection.

The relatives we spoke with told us they would feel comfortable in contacting the manager regarding any concerns, although it was sometimes difficult to get hold of them. One relative said, "Yes, we've not had any problems with that at all." Another relative told us that, whilst they had experienced difficulties getting hold of the manager in the past, this had improved recently. Another relative told us that they often had difficulty getting hold of the manager and their messages hadn't always been responded to. This meant that the manager's response to queries was inconsistent and people did not always receive the same level of service. We could not be sure that First Class Care had received all relevant communications to them because the manager told us they did not always receive all of their post, due to delivery access issues.

We found there was a lack of culture of shaping the service around the needs and preferences of people that used it. There had not been any staff meetings for a significant period of time which meant opportunities for staff to get together and discuss the development of the service were not available. The staff we spoke with told us they felt able to raise issues and make suggestions. Staff felt their views

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Is the service well-led?

were taken seriously and that they were confident about speaking up. Staff told us they would feel comfortable saying they had made a mistake and that the manager would support them to learn from this and improve.

The service had not had a registered manager for five months. The nominated individual told us they were going to apply to become the registered manager. However, we were concerned that they did not fully understand their responsibilities under the Health and Social Care Act 2008. First Class Care was registered at an incorrect address at the time of our inspection and they had not taken the appropriate action regarding this. This meant they had breached a condition of their registration. Despite the manager submitting an action plan following our previous inspection, the required improvements had not been made. The quality of the service had deteriorated significantly because of a lack of appropriate governance and leadership.

The relatives we spoke with provided mixed feedback about how well-led the service was. Some relatives felt that the service was not well organised and told us they had experienced difficulty in getting hold of the manager. However, other relatives told us they had not experienced such issues and felt the manager was doing a good job. At the time of our inspection there were no administrative staff employed to manage the office or handle phone calls. The telephone system diverted to the manager's mobile phone and they would not always be available to take calls.

The manager had not ensured that all resources were available to provide a good quality service and ensure staff were well supported. Due to the lack of investment in staff training, people were supported by staff who had not been appropriately developed. The lack of adequate management and administrative structure meant that people did not receive appropriate care and any issues were not identified and acted upon.

Records were not accurately maintained or securely stored and the quality of service people received was not monitored which meant there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users did not meet their needs or reflect their preferences. **Regulation 9 (1) (b) and (c).**

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person had not acted in accordance with the Mental Capacity Act (2005). **Regulation 11 (3).**

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There was a risk that care may not always provided in a safe way for service users because assessments of the risks to the health and safety of service users of receiving the care had not been properly completed. **Regulation 12 (1) and 2 (a).** People's medicines were not managed safely. **Regulation 12 (2) (g).**

Regulated activity	Regulation
Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not established or operated effectively to prevent abuse of service users. **Regulation 13 (2).**

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The nutritional and hydration needs of service users had not been met. **Regulation 14 (1).**

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes were not operated effectively in respect of assessing, monitoring and improving the quality and safety of the services provided. **Regulation 17 (1) and (2) (a).** Systems or processes were not operated effectively in respect of assessing, monitoring and mitigating the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. **Regulation 17 (1) and (2) (b).** Systems or processes were not operated effectively to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; **Regulation 17 (1) and (2) (c).** Systems or processes were not operated effectively to maintain securely such other records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity, and the management of the regulated activity. **Regulation 17 (1) and (2) (d).** Systems or processes were not operated effectively to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. **Regulation 17 (1) and (2) (e).**

This section is primarily information for the provider

Enforcement actions

Systems or processes were not operated effectively by the provider to evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e). **Regulation 17 (1) and (2) (f).**

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons had not been deployed in order to meet the requirements of this Part. **Regulation 18 (1).** Staff had not been provided with appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. **Regulation 18 (2) (a).**

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Recruitment procedures were not operated effectively to ensure that persons employed were of good character. The information specified in Schedule 3 was not available for all persons employed. **Regulation 19 (1) (a), (2) (a) and (3) (a).**