Health Care Resourcing Group Limited

CRG Homecare Stockton

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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Castle Rock Recruitment Group Stockton (CRG) is a domiciliary care agency which provides care and support to people living in Stockton-On-Tees and Redcar-In-Cleveland. The service provides personal care to people living in their own houses and flats. It provides a service to older adults who live with a dementia, to young adults and older people with physical or mental health difficulties and younger adults living with a learning disability and autism.

This service also provides care and support to people living in specialist 'extra care' housing in Stockton-On-Tees. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is rented, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care [and support] service.

At the time of the inspection there were 311 people using the service.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

A registered manager had been in post since 7 March 2016, however they had not been working at the service for at least one month. During the interim period, the regional manager was based at the service and an acting manager was in place. 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 the last inspection on 31 May 2017, we found improvements were needed to the quality of record keeping at the service. Records relating to the care and treatment of people using the service were not always accurate or updated when people's needs changes. Audits had not identified these concerns. After the inspection, the provider supplied an action plan, which was dated 21 August 2017 which said, all of the required improvements would be completed by 31 October 2017.

At this inspection, we found these improvements had not been made. In May 2018, the provider had accepted a significant number of new care packages. Local authority commissioners had raised a number of concerns around the operation of the service. The provider agreed as part of the serious concerns protocol, to a voluntary embargo on accepting new care packages in some aspects of the service. After inspection feedback, the provider placed their own embargo across all aspects of the service.

At this inspection, we found staff were not responsive to risk and safeguarding alerts had not always been

raised when needed. Accidents and incidents were not routinely recorded and systems had not been in place to ensure lessons were learned. Risk assessments were not always in place. Those in place lacked information about how to reduce the risks to people. Medicines were not always managed safely for people and records had not been completed correctly. There were gaps in recruitment and there were insufficient staff in all areas of the service to meet the needs of people. Infection prevention and control procedures were not routinely followed.

Staff had not been supported through their induction. Supervision, appraisal and training were not up to date. Staff lacked understanding about people's nutritional needs, as a result there was a lack of oversight. People were supported to make and attend healthcare appointments, however guidance from health professionals was not routinely available in care records. People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service did not support this practice.

We received mixed reviews about the care and support which people received. Some people told us missed and late calls impacted upon the quality of their care and this had not always provided them with a good experience of the service. Some people told us their privacy and dignity had been impacted at times, which we deemed to be a training issue. Other people spoke positively about the quality of care which they received from care staff and told us care staff were kind and friendly but felt that changes needed to be made in the office to improve their overall quality of care. People had not been routinely involved in planning and reviewing their care. Some people using the service did have access to advocacy services.

Care records did not contain the information needed to provide safe care to people which was in line with their needs wishes and preferences. People were supported to attend day centres, activities of daily living and areas of interest in line with their agreed care packages. The provider had identified that complaints had not been investigated and dealt with as they would have expected and changes had been made to address this. No-one was receiving end of life care during this inspection.

At the time of inspection, the service was under significant pressure. The regional manager was open and honest about the position of the service and had started to make improvements. Recruitment was ongoing in all areas; some training had been put in place. The number of office based staff had increased which provided additional oversight of care packages. This had started to reduce the number of missed and late calls. Staff told us they were committed to staying with the provider. Safeguarding alerts and notifications had been submitted without delay.

The provider was working with Stockton-On-Tees local authority to make improvements and had agreed to hand care packages back to them to reduce existing pressures on the service. The provider had made the decision to withdraw from its contractual arrangements with Redcar and Cleveland local authority and were working through this at the time of inspection.

An acting manager and regional manager were in place during the inspection. A critical review of the service had taken place. This audit had identified multiple areas where improvements were needed. The provider had devised an action plan from these findings and was also using information from the local authority commissioners visits to ensure all areas for improvement were addressed. The senior management team had prioritised the order in which these issues would be addressed with high risk areas being resolved first.

When we visited, the provider had started to make improvements and had started to reduce risks by employing additional staff, training the staff team, implementing safeguarding procedures, ensuring staff safely assisted people to move, and reviewing medication practices. However, these actions had been

recently introduced so were not embedded.

We found multiple breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to requirements relating to safe care and treatment, good governance and staffing. We also identified a breach of the Care Quality Commission (Registration) Regulations 2009 for failing to submit notifications without delay.

You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.'

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures."

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff were not responsive to risk. Risk assessments were ineffective. There was no evidence of lessons learnt.

Prior to inspection, accidents and incidents had not been routinely recorded and safeguarding alerts had not been submitted in a timely manner.

There were insufficient staff on duty in all areas of the service to deliver safe care. Recruitment was not effective.

Medicines were not managed safely. Infection prevention and control procedures were not consistently followed.

Is the service effective?

Inadequate

The service was not effective.

Staff had not been supported to carry out their role through induction, supervision, appraisal and training.

People were not supported with their nutritional needs safely. This increased the risk of harm to people

Staff lacked understanding of the Mental Capacity Act 2005. Assessments had been completed when not needed. Court of protection information for people was not available.

People were supported to make and attend healthcare appointments. Recommendations from health professionals were not available in care records and staff were not familiar with these recommendations.

Is the service caring?

Requires Improvement

The service was not always caring.

Staffing levels had impacted upon the quality of care which people received.

Most people told us they were happy with the support which they received from care staff.

People told us they were generally happy with the support they received from care staff.

People were not involved in planning and reviewing their care. Advocacy services were involved with some people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were not person-centred and did not provide staff with the information needed.

People were supported to carry out activities of daily living, attend day centres and the community in line with their agreed packages of care.

The provider had recognised complaints had not been dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Ineffective quality assurance measures were in place. Notifications were not always submitted without delay.

The provider had started to put resources in place to improve the stability of the service.

The provider had responded to the feedback during inspection by placing an embargo on the whole service and supplied us with a detailed action plan.

CRG Homecare Stockton

Detailed findings

Background to this inspection

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

Prior to inspection, concerns had been raised with CQC. These included concerns about staffing levels, missed calls, the management of medicines, quality of care, communication, contacting the office and record keeping. We incorporated these concerns into our inspection plan and reviewed these areas during the inspection.

The service had been placed in a serious concerns protocol by Stockton local authority. We attended the meetings which had taken place and had shared relevant information with them at these meetings.

We carried out an announced inspection on 10 September 2018. We gave the service 48 hours' notice of the inspection visit because we needed to be sure someone would be in the office and we needed to allow the service time to contact people using the service to let them know about the inspection.

Inspection site visit activity started on 12 September 2018 and ended on 17 September 2018. Two adult social care inspectors and one pharmacist inspector carried out a site visit on 12 September. One adult social care inspector carried out site visits on 13 and 17 September 2018. During the site visits we reviewed records and spoke with staff.

One Expert by Experience carried out telephone calls to people using the service on 17 September 2018. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. One adult social care inspector carried out telephone calls to people and staff on 28 September 2018 and 2 October 2018.

Before our inspection we reviewed all the information we held about the service. We examined the notifications received by CQC. Notifications are changes, events or incidents that the provider is legally

obliged to send us within the required timescales. We also contacted Redcar and Cleveland local authority Commissioning team, and Stockton local authority. We used the information shared with us as part of our inspection planning.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 21 people using the service and four relatives. We also spoke with the regional manager, acting manager, deputy manager, quality manager, three care co-ordinators, a team leader and seven care staff.

We reviewed 14 care records, four recruitment records, four induction records and 10 supervision and appraisal records. We also reviewed the training matrix for all staff and records relating to the day to day running of the service.

We did not use the Short Observational Framework for Inspection (SOFI) because people lived in their own homes. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

Prior to inspection, safeguarding alerts had not been raised when needed to and reasonable action had not been taken to address the concerns. This meant further safeguarding incidents occurred because a lack of action had been taken. There were discrepancies in the number of accidents and incidents recorded. Once these concerns had been identified, the provider commenced its own investigation into the matter. New systems were put in place to ensure safeguarding alerts, accidents and incidents were raised when needed. Retrospective safeguarding alerts were put in place. From our attendance at serious concern protocol meetings with Stockton-On-Tees local authority we were aware that safeguarding alerts had been upheld. Those upheld were a result of missed calls which had resulted in missed medicines or people being left without care for significant periods of time. At inspection, we could see the new systems in place had started to reduce the volume of missed calls and missed medicines, however further improvements were needed because staff did not always recognise when incidents needed to be reported. Lessons learned exercises had not been carried out with staff.

Staff knowledge of risk was limited. This meant they were not responsive to risk. Staff were often providing care and support to people without the necessary information to reduce the risk of harm to people. They had not raised concerns that information about risk was not in the care records. Neither had they raised concerns that risk assessments didn't provide sufficient information about the risks in place and how to reduce those risks. Care records stated that people were at risk of choking, however there was no information about how to manage this risk or the action staff needed to take if a choking incident occurred.

In general pre-assessment records and care records lacked information, which further increased the risk of harm. Records in place were not always suitable for the people using the service. For example, risk assessments for management of skin integrity were designed for people who were living in 24-hour accommodation. Actions to reduce the risk of harm included positional changes on a one to two-hour basis, yet the care package did not provide sufficient time to carry out these changes. This meant staff could not actively manage these risks and they had gone unnoticed in quality assurance measures. Moving and handling assessments did not include how many staff needed to be involved to support people to move. One person experienced muscle spasms but staff had not understood that there was a risk of choking as a result.

Risk assessments had been completed incorrectly. For example, people with extremely high risks of developing pressure ulcers were deemed to be a high risk. This meant there was a danger that the wrong level of support was put in place. We reviewed a record for one person which noted problems with their hoist. However, there was no information to confirm that these had been addressed and the hoist was in good working order. In another person's file, the record stated that staff had been 'using the wrong straps and the client had been wonky in the hoist.' There was no information to show this had been resolved. We raised this with the regional manager who immediately got staff to check that the hoist was fit for purpose.

Staff did not understand the risks associated with infection prevention and control. Whilst personal protective equipment was available, staff did not follow appropriate guidance when they were unwell. When

we spoke with staff who were involved in delivering personal care to people, we found they did not follow safe practices. For example, they were not bare below the elbow when delivering personal care. This goes against the procedures for managing the risks of infection prevention and control.

The level of support that people had with their medicines was not clearly documented. Staff had recorded the level of support that individual people needed in their care plan, however for one person we visited, this had changed and the care plan was not updated. For another person the level of support differed on two different pages of the same plan. One person was administering their own inhaler and there was no risk assessment completed in accordance with the provider's medicines policy. This meant we could not be sure that staff were supporting people to look after their own medicines safely.

Care staff had responsibility for obtaining medicines for some people but this was not clearly noted in the care plan and there were no procedures documenting how this would be done in line with national guidance. For one person this had resulted in one pain relief medicine, which was taken regularly, being out of stock.

Records relating to medicines were not completed correctly placing people at risk of medicine errors. Staff had failed to fully complete medicine administration records (MAR). We also found that the medicines recorded on the MAR did not match the medicines that staff administered. For two people, the strength of two medicines were not correctly listed. Where medicines were not administered, the reason for this had not been recorded. Instructions for some people receiving medicines 'as and when required' were missing. This information is important to ensure staff are aware of the circumstances under which these medicines should be given. Staff did not have information about when and where to apply topical creams.

The provider recognised that the management of medicines needed to be improved. An action plan was in place to support the new systems they were putting into place.

The provider had taken on a significant contract of 3000 hours of care packages in May 2018. It quickly became apparent that the staff needed were not in place. This resulted in high volumes of missed and late calls. People we spoke with voiced their dissatisfaction about this.

Some people and their relatives had expressed concern that the right kind of staff with the skills and experience needed to provide care and support to people had not been recruited. In the records reviewed, gaps in employment had not been explored and for one staff member only one reference had been received, which was dated after their start date. Their DBS was also dated after their start date. This meant the provider had not taken the appropriate action to ensure all the necessary checks of this staff member had been carried out to ensure the safety of people using the service. This incident was raised as a safeguarding alert and the provider took immediate action to remove the staff member from duty until the DBS had been sought.

We received very mixed reviews about the timeliness of calls. One person told us, "I regularly have missed calls. It is hard to get on to the office." One person expressed their dissatisfaction that care staff arrive at different times, for example, a morning call could be 7:30am, 8:30am or 9am. The person told us the calls did not always suit them, yet they had not been asked their thoughts about changing the call times. Another person told us, "I don't want to go to bed at 19:30."

One staff member told us, "We have too many different carers involved with clients. The clients don't get their rotas in time. They have to ring up [the office] and see when a carer is coming." One relative told us, "The rotas are a problem. Quite often, we don't get a rota so we don't know who is coming. We often find

staff can't cover the rota [planned calls] which staff can't cover. This had ended up with regular staff picking up those calls, resulting in them working a lot of hours to make it work."

Some people were satisfied that care staff arrived on time, yet other people were dissatisfied with the frequency of missed and late calls. From the feedback received, we established that people who received the same carers did not have an issue with missed and late calls. One person told us, "I have the same person [staff] who has been coming for years. They are always on time." A relative told us, "We have the same person [staff] daily for [person using the service]. They are regular and reliable. They always arrive promptly."

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

From the available information we struggled to determine how many calls people were to have each day. The information in the care records from the local authority did not match what was currently being delivered. Thus, we often could not determine if the number of calls delivered were what was expected. However, people, their relatives and staff told us there were insufficient staff employed in all areas of the service to deliver safe care and support to people.

Staff told us there were not enough care staff and sickness caused significant problems. One staff member told us, "We don't have enough carers and sickness is problematic." Another staff member told us, "We need more carers. We do seem to struggle if staff are off sick, especially at weekends." Many staff spoken with told us they needed 'runners.' These are staff who don't have any allocated calls, but pick up calls when staff are sick or cannot make a call because they are delayed.

This was a breach of regulation18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People's physical, mental health and social needs were not fully assessed. This meant that support was not always delivered in line with best practice guidance. Staff were not aware of current best practice in place when we talked with them. Care records were not completed in line with best practice guidance, for example, for medicines, dementia care and learning disabilities. People were not always protected under the characteristics of the Equality Act, because they had not always been involved in making decisions about their care. Technology was in place to monitor calls with the aim of improving service delivery.

People were not adequately supported with their nutritional needs. Recommendations and guidance from health professionals for nutritional and swallowing concerns were not routinely found in the care records. Staff were following information from the care records without the required guidance in place or without knowing where the information they received had come from. For example, records showed that one person required a pureed diet because of a swallowing risk. This person was not involved with a speech and language therapy team and therefore there was no guidance to show how meals needed to be prepared. After speaking with a relative, staff established that there was no choking risk.

Some people were given blended meals, but staff could not demonstrate that these had been blended to the correct consistency. In the records, we saw that one person who required a pureed diet had been given lasagne blended with soup. Lasagne cannot be pureed because of the gluten in the pasta which does not break down. Staff had used the soup to break down the pasta, but had not considered how this would taste.

Another person had been to the day centre and given chicken, spaghetti and chips but was on a pureed diet. We asked how the staff member had worked with the team at the day centre to ensure this was suitably pureed. The team leader told us that staff were reliant on the day centre serving the correct food but recognised that if the person choked it would be the person responsible for assisting them to eat the food that was accountable. The deputy manager took immediate action to contact the day centre to discuss how people's dietary needs were met.

Care records did not support staff manage the risks associated with nutrition. For example, records were not clear about the foods and fluids people could eat. There was no information about the consistency of thickened fluids people needed. There was no evidence of likes and dislikes for people who had difficulty communicating. For these people, there was no information to show how staff supported people with the nutritional choices. Where there was a choking risk, there was no detail about triggers for choking, how food needed to be prepared, how to support people to eat and how to deal with a choking incident.

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

New staff had not been supported through an induction programme. Staff had not carried out the training and competency assessments needed to support people with their care needs. Where observations of

practice had been carried out, they had not been completed in the timeframes indicated by the provider. Staff had not received reviews of practice to determine if additional support was needed. We determined that this lack of support during the induction was in response to a lack of staffing. This was not safe practice. The overall quality of records completed were poor, information was not always legible and records had not always been signed or dated by the people involved.

Ineffective systems were in place to support staff who had completed their probationary period. This meant there were insufficient staff employed to provide supervision and appraisals to staff. Competency assessments (in addition to reviews) had not been carried out either. These support measures would have identified that staff needed further support to carry out their roles safely and that training was urgently needed. Supervision and appraisal records were not available for all staff. This meant we could not see how the management team at the service was supported to run the service. From the records reviewed and from speaking with staff, we determined that staff did not receive regular supervision and appraisal. One staff member told us, "We only get supervision occasionally. It's very very rare."

In August 2018, the management team in the office of the service had attempted to carry out a form of one-to-one contact with some staff. Inconsistent records had been completed and records had not been filed appropriately. This meant we could not establish which staff had received a one-to-one and which staff still needed to have one. At inspection, the regional manager showed us the provider's records which were to be used for supporting staff and a matrix was being developed to plan supervision and appraisal sessions with staff.

There were gaps in all areas of training. This included infection prevention and control, equality and diversity, health and safety and the Mental Capacity Act 2005. There were some aspects of service specific training which had not been put in place for staff. This included dysphagia, learning disabilities and autism.

At inspection, the provider had organised medicines training for all staff in response to their own recognition of medicines concerns. They were also looking at the current training package in place for the service to identify which areas of training were outstanding, which needed to be completed again because of poor practice and those which needed to be sourced as specialist packages to meet the needs of staff who were supporting people with individual needs.

We received mixed reviews about the skills, knowledge and experience of care staff. Some people and relatives told us staff did not have the necessary skills to carry out the care and support needed and some care staff needed direction about what to do and how to do it. Other people told us that staff had the skills needed and felt they were well-trained in all aspects of their care.

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

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

This Act is limited to care homes and hospitals. In the community where people live in their own homes, people are subject to a court of protection authorisation. This is a superior court record created under the MCA (2005) and gives an appointed person jurisdiction over the property, financial affairs and personal

welfare of people who lack mental capacity to make decisions for themselves.

The regional manager was aware that when people lacked capacity and were deprived of their liberty this would need to be referred to the Court of Protection. They also understood the need to consider 'best interests' decisions however it was evident from the care records that staff did not understand the principles of the MCA. Staff identified people as lacking capacity when this was not the case or when it was the case they did not have relevant paperwork in place. For instance, when staff locked medication away it was unclear why this action was being taken. Staff had not received training or had not understood their training and the quality assurance systems in place had not recognised this. Where care staff had carried out MCA assessments and deemed people did not have capacity, no further action was taken to address this.

Records had been signed by relatives and representatives even when people had capacity and records were unclear about the reason for this. Care records for people deemed not to have capacity did not show how staff supported them to make choices, such as with their diet.

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

Staff supported people to make and attend appointments with health professionals. Where staff had been concerned about people's health they had directed relatives to contact health professionals or they had contacted the office to seek support. Records showed that staff had followed the directions given to them in these cases. Where people had specialist health conditions, such as diabetes, people told us staff understood their needs. One person told us, "I am diabetic and they [staff] know what to do for me." Another person told us, "When my carer arrived, she could see that I didn't look well. After checking she [staff] called a close family member who lived locally. A GP was called and I was taken to hospital by ambulance where I stayed for several days." A relative told us, "The carers were concerned by [person using the service's] behaviour and realised it was not caused by their usual condition. I was advised to call the GP who visited and transferred [person using the service] to hospital where they are still undergoing treatment."

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us the volume of missed and late calls impacted upon their overall quality of care and their experiences of the service. People told us staff were often rushing to complete their call because they were conscious that they needed to get to another call. One person told us, "Carers are helpful, chatty and friendly, but this does depend on time. Sometimes they [staff] are in and out, rushing off because they are short of staff." This had impacted upon people's dignity at times, for example, not allowing people the time they needed, little time for a chat and not always making sure people were covered up during personal care. In a small number of cases, people told us care staff of their preferred gender had not been allocated to them and this had not been discussed with them. At times, people had been left for longer than usual because calls had been missed or delayed. People told us about the negative effects of this on their well-being and expressed their frustration because it also impacted upon their daily activities. Some people had not had a positive experience with care staff, but had raised this with the care office and action was taken to address this.

During our discussions with people and their relatives, they all told us the best thing about the service was the care staff. People and their relatives spoke positively about care staff. They told us care staff knew about the care needs and felt at ease during visits from staff. One relative told us, "I have no worries about [person using the service] when the carers are here. They understand the situation and deal with them brilliantly." Another relative told us, "The carer does the daily job capably. They are kind and attentive. We have a good relationship and they are very sympathetic to our needs and they are entirely trustworthy." One person told us, "They are all nice girls [staff]. We have a laugh together."

We identified some people received more consistent care because they had a stable team of staff involved in their care. Some people told us they had the same team of staff involved in their care and said they valued this. One relative told us, "We have a regular carer who is reliable and able to care for [person using the service] perfectly." One person told us, "I have had the same carers for years. They are kind and caring towards me."

Relatives told us that care staff demonstrated the skills needed to deliver the care and support to their loved ones. At times, they told us, staff did this in difficult circumstances yet were able to remain professional. Relatives told us staff demonstrated empathy towards people in these situations. One relative told us, "The carers are brilliant with [person using the service]. They [staff] have great patience and understanding. They [staff] have formed a nice relationship and even though [person using the service] can get nasty with them, they persevere. I cannot fault them [staff] in any way. I am embarrassed by the behaviour, but they [staff] handle [person using the service] so well and with a great sense of humour. They look out for me too."

Care staff told us they enjoyed working in their roles. One staff member said, "I love my job. I like meeting people and getting to know them. It's good to build relationships with people because you can pick up when they are not themselves." Another staff member told us, "I like caring for other people." A third staff member told us, "The best thing for me is when [person using the service] is enjoying themselves and living as independently as possible."

Relatives told us staff involved them and ensured they maintained a relationship with them. For example, one relative told us, "They are great girls [staff]. Not cheeky or forward. They are very polite and always find the time for a little chat." Another relative told us, "The staff do care about us," and, "I like the carers. They have been coming for a long time." A third relative told us, "The carers make every effort they can for us."

People and their relatives were not involved in planning and reviewing the care which people needed. Many of the people we spoke with were not aware of a support plan which detailed the care and support they needed and told us they had not been asked about their preferences and had not been asked to review their care. One relative told us, "[person using the service] has not had a review recently." One person told us, "I think I had a review two years ago." A relative told us, "We've not had any reviews. They [office staff] were going to come, but didn't."

Information was not available in accessible formats for people. For example, care records were not available in easy read format for people living with a learning disability or in large front for people with visual impairments.

Requires Improvement

Is the service responsive?

Our findings

We found that staff had not always completed an assessment of people's needs prior to starting a care package. Therefore, we could not determine what some people's needs were or what they expected from the care package.

Some people did not have any care records in place. Where care records were in place, they did not provide sufficient information about how to deliver support or what people could do for themselves. For example, in a medication support plan for one person, the record stated, 'Medicines are given to me by staff due to me forgetting things.' In another person's support plan for communication, the record stated, "[Person's name] has no verbal communication. Care workers need to make eye contact with me and I would like you to make a noise and wave your arms." In a third person's nutritional care plan stated, "[Person's name] needs full support to be fed either by PA or carer. Their food always need to be prepared. Glass with straw/beaker to be used when having a drink.' This showed staff did not have the information they needed to deliver person-centred care and support to people.

The quality of the care records increased the risk of harm to people because staff were not able to establish basic information from them, such as if people had a personal assistant (PA) not employed by the service and how care staff worked alongside them. Also, working hours and responsibilities of PA's and care staff. Records did not show if PA's had completed their visits. No action had been taken to check that PA's were able to support staff when moving and handling the person. We discussed this with the manager who took immediate action to address all the issues we highlighted in this area. They had identified these deficits in the care records and was in the process of working through records and improving them.

Care records did not show how to support people with specific health conditions. For example, for one person who experienced muscle spasms, the records did include information about frequency or length of time spasms could be experienced, the action staff needed to take and the risk to the person when spasms occurred. For example, ensuring the environment is safe, assisting with specific medications and keeping a record of the incident.

The risk of harm was further increased because care records had not been updated to reflect current needs. This meant staff were delivering care and support to people which was not identified in the records. If staff, unfamiliar with people's needs were to be involved in their care, there was a risk that people may not receive all of the care and support which they needed.

People and staff expressed concern about their records. One person told us, "My care records are out of date. My needs have changed." One staff member told us, "The idea of a care record is to tell us about the client. We should be able to read it and deliver support to them." Another staff member told us, "Some clients care records are empty. Where they are in place, not all key information, such as GP details are kept in the same place. This causes problems when we need the information quickly."

Some of the care records reviewed during this inspection were difficult to read. It was not always easy to

establish what care and support people had received, where people had been supported with their nutrition and what they had eaten. Care records for people with sensory impairments were extremely limited. They did not support people to be as independent as they could be. There was no information about how to communicate with people verbally or how to present written information, such as in large font or in easy read format.

Some people were supported to go into the community as part of their agreed care packages. Where this was the case, we could see these visits took place and were important to people to maintain their social contact. One staff member told us, "I go with [person using the service] to the day centre. We also go to the cinema, Fellowship and out with their family."

Prior to inspection, the provider had identified that concerns and complaints had not always been dealt with appropriately. They had addressed this and the records we reviewed of recent complaints showed the action taken to address the concern and the outcome. Where actions had been identified, they had been put into place or changes were in the process of being completed.

During our discussions with people and their relatives, we identified that where they had raised concerns, such as not being happy with a member of staff, action had been taken. People had raised concerns about staffing levels and late and missed calls, the provider had started to address the wider issues of this by way of recruitment and call monitoring.

Most people knew how to make a complaint. Many people were aware of the complaints procedure and other people told us they would speak to their carer or would ring the office.

At the time of the inspection, the regional manager told us that there was no-one using the service who was receiving end of life care. Staff did not have up to date training to deliver this support to people. The provider had recognised that improvements were needed across the service before this type of specialist support could be delivered.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us the service needed to make improvements to improve their overall quality of care. These included staffing levels, timeliness of calls and contacting the office. One person told us, "There are massive communication problems. It is hard to get onto the office." Another person told us the service was "Chaotic." One staff member told us, "It's not easy to get in touch with the office." Another staff member told us, "There is no answer when you ring the office. We could be seeking support for an urgent situation."

Some staff worked in a supported living building. They told us there was no manager on site for support, that mobile phone reception was poor so they were not always able to contact the office. They also told us it could be difficult to take a break and go out of the building because minimum staffing levels needed to be in place for health and safety. The provider was aware of this and action was being taken to address this.

Overwhelmingly, people, their relatives and staff told us communication needed to significantly improve. Examples given included, having rotas for people and staff which match and supplying them in sufficient time. Staff told us there was a lack oversight with record keeping. One staff member told us, "The biggest problem with [care] records is the lack of checks. They should be checked weekly. They [the provider] could nip things in the bud quickly." One staff member told us, "We know what we need to do. It's the hours and the resources to make the changes. More so around assessments [skills to undertake a thorough assessment]. Having enough staff in place to undertake assessments."

There had been many staffing changes at the office. Many staff expressed their concern that they did not know who staff were in the office and what their roles were. One staff member told us, "There are lots of bodies in the office. It's not welcoming and I feel intrusive going in. There are no clear defined roles. Everyone is just mucking in."

The registered manager had left the service over one month ago yet care staff did not know why. Some staff were not aware that an acting manager and regional manager were working at the office to support the service to make improvements. Where people and staff were aware of this, all provided positive feedback about them, describing them a "Good," and "Lovely." One staff member told us, "[Regional manager] supported me through a difficult situation with a client. They phoned me regularly to provide support. It was reassuring and they were supportive throughout." Another staff member told us, "[Regional manager] is interested in what I have to say. I have a lot of respect for them." Staff told us that there is never a problem with [deputy manager] because they ring us back and deal with everything." We could see these staff promoted the values of the organisation and were transparent with us during the inspection.

Quality assurance measures had not been consistently completed. Where completed, action plans were not always in place or addressed. Consistent feedback had not been obtained or used to improve the quality of the service. The regional manager told us that since coming into post they had become aware that the service had not operated in line with expected practice. They had been taking action to make improvements, however felt more were needed.

The audits which had been carried out had not identified the same level of concerns which were identified during this inspection. We also found there were gaps in the frequency of auditing. The regional manager had told us they had been trying to deal with the volume of day to day issues which had presented since they had taken on a new contract in May 2018. They now felt that they had made progress with this and had started to look at the improvements needed to improve the overall quality of the service.

There were areas of the inspection where the provider had not identified the same level of concerns as those identified during this inspection. However, there were areas where the provider had already started to take action. Recruitment was taking place. Staff had been allocated to monitor calls and this had reduced the number of late and missed calls. An action plan and training was in place to improve the effectiveness of medicines at the service. A medicines passport was in the process of being introduced, which would also act as a supplementary record if information relating to prescribed medicines was not available. Through their own quality assurance measures, the provider was aware of issues with missed calls, medicines and records. They were also aware that morale within the staff team was low. These areas had been included into an action plan and we could see that changes had been made in each of these areas.

Feedback was provided continually throughout inspection. Staff were responsive to this feedback and immediate action was taken where needed. For example, action was taken to obtain medicines which were not in place. In response to nutritional concerns, immediate action was taken to liaise with the person's family to determine whether there was a risk. Observations of practice took place and a review of the person's care records took place. This meant that the risk of harm to this person had reduced. We were shown an updated support plan on the third day of inspection and could see that this was much improved. Further development of this was needed, however staff had been responsive and shown they had taken on board our feedback. Plans were in place to ensure all staff attended team meetings and participated in supervision. The aim of this was to support each other to improve the overall quality of the service.

People and staff were not actively involved in providing feedback about the organisation, however surveys were due to go out shortly. This feedback would be incorporated into the overall action plan for the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had worked with us prior and during inspection in an open and transparent way. They had worked with local authority commissioning and safeguarding teams to make sure lessons were learned and improvements put in place.

In response to inspection feedback overall, the provider made a decision to place an embargo on the whole of its service. They told us that at present they were not accepting additional care packages and only when significant improvements were made would this be re-considered. They shared a robust action plan with us and agreed to share an update plan each month.

Notifications had not always been submitted when needed or had not been submitted without delay. This included a death in October 2017, the absence of the registered manager from June 2018 and a safeguarding incident in June 2018.

This was a breach of regulations 14, 16 and 18 of the Care Quality Commission (Registration) Regulations 2009. We will take action outside of this inspection to address this. We will report on any actions once they have been completed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment (1) People using the service did not receive safe care and support. This included the management of risk, knowledge and response to safeguarding, the management of medicines, infection prevention and control and missed and late calls.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance (1) Systems to monitor the quality of the service were ineffective and did not ensure compliance.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing (1) and (2). There were insufficient staff to provide safe care and support to people. Staff were not supported to carry out their roles.