MSC Home Care Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 29 August and 3 September 2018. At our previous inspection in October 2017 the service was rated as 'Good' overall, with improvement required in the key question of 'Is the service responsive?' in relation to communication. At this inspection we found that the quality of care had deteriorated significantly and there were multiple breaches of regulation. 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.

MSC Home Care Limited is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults and people who may have a disability or conditions such as dementia. There were 80 people using the service at the time of our inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found there was lack of oversight and coordination of the service and attempts to put systems in place

had not been effective. Issues were not always being identified which placed people at continued risk of harm.

People did not have risks associated with their care or health conditions assessed, planned for or mitigated which left them at risk of harm. Staff did not have guidance to assist them to keep people safe at all times. We could not be assured that people were always receiving their medicines as prescribed.

Staff were not always recruited safely and staff were not always effectively deployed to ensure that everyone received their planned care. People were not always protected and lessons were not always learned as timely action was not always taken.

Staff did not always have the knowledge and skills to care for people effectively and staff had mixed feedback about the support they received. People's rights were not protected as their capacity had not been assessed when necessary and representatives were consenting to care when their legal right to had not been verified. There was no guidance and staff did not know what to do in relation to some peoples' health conditions. Referral were made to other health professional but timely action was not always taken to ensure this guidance was incorporated into people's care and care plans.

Risks associated with people eating were not always considered when necessary, however some people told us they were offered a choice of food and drinks and the food was well-presented.

People did not always have a consistent team of staff which they felt impacted upon the quality of support they received. We were also told of poor conduct by some staff member which caused people and relatives upset. People were not always informed if their staff were going to be late.

There were minimal care plans in place by the service and people and relatives found the lack of guidance for staff to be a problem and meant care was not always personalised. If people raised concerns they did not always feel listened to and action was not always taken or responded to.

People, relatives and staff did not find the service to be well run and found communication to be sometimes difficult. People did not always feel they could speak to someone from the service if they needed to.

People and relatives found their individual staff kind and caring.

People were protected from the risk of cross infection as staff had personal protective equipment.

The service was not supporting anyone who required palliative care.

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.

Risks to people's health and well-being were not being assessed and planned for.

We could not be assured that people were always getting their medicines as prescribed.

Timely action had not been taken following the identification of concerns.

People did not always receive their required calls and staff were not deployed safely.

People were not always protected as recruitment checks on staff were not always of satisfactory quality.

People were protected from the risk of cross infection.

Is the service effective?

Inadequate

The service was not effective.

Staff did not have sufficient training to support people effectively.

People did not always have their rights protected under the Mental Capacity Act 2005.

There was not always guidance about people's health conditions and staff did not always know what to do.

Risks associated with people eating were not always considered.

People had access to other health professionals but advice was not always followed.

Is the service caring?

Inadequate

The service was not caring.

People did not always have a consistent team of staff visiting

them.

People were not always informed if staff were going to be late.

Some people and relatives felt that staff were kind.

Is the service responsive?

Inadequate

The service was not responsive.

People, relatives and staff felt there was not always enough information available to support people effectively.

Minimal care plans developed by the service were in place for people.

People did not always feel their complaints were listened to or responded to.

The service was not supporting anyone requiring palliative care.

Is the service well-led?

Inadequate

The service was not well-led.

There were significant concerns about the oversight of the service and a lack of timely improvements being made following feedback.

Quality assurance systems implemented were not effective at identifying areas for further consideration or action.

People, relatives and staff felt communication was poor and did not always feel listened to.

MSC Home Care Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

The inspection took place on 29 August and 3 September 2018 and was unannounced. The inspection was carried out by two inspectors. There was also one Expert by Experience who made telephone calls to people and their relatives on 31 August 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.

We looked at information we held about the service including statutory notifications submitted. Statutory notifications include information about important events which the provider is required to send us by law. We also asked Healthwatch and local commissioners if they had any information they wanted to share with us about the service. Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health and social care services. We used this information to help plan our inspection.

We spoke with seven people who used the service and five relatives. We also spoke with seven members of staff and three health and social care professionals. In addition to this we spoke with the registered manager, a director, the Business Development officer and the Nominated Individual. A Nominated Individual is someone listed from the provider who is the main contact for the CQC. We reviewed the care plans for nine people who used the service, as well as their medicine records. We looked at management records such as quality audits and the ways in which the provider monitored the service. We also looked at recruitment files for six members of staff.

Inadequate

Is the service safe?

Our findings

At the last inspection this key question was rated good. At this inspection we found the quality and safety of the service had deteriorated and it was now rated as inadequate.

We found that risks to people were not assessed, planned for or being mitigated to try and keep people safe. One relative said, "Due to my relative's condition they can't direct staff to their needs as well as they could. Sometimes new staff will come who don't know them and it will be difficult as my relative gets very breathless." A social care professional said, "Risk assessments by the service are part completed or incomplete." Some people had particular health conditions however guidance was not always available for staff and some staff did not know how to keep some people safe. One person had health conditions that meant they could injure themselves or injure staff. There were no risk assessments or plans in place to help direct or guide staff about how best to support the person. This left the person at risk of experiencing unsafe or inconsistent care. Some staff confirmed they felt there wasn't always enough guidance to support people. One staff member said, "They [person's name] need an up to date risk assessment." Another staff member said, "I don't think plans have enough detail."

We were told that some people could have behaviour that challenges. There was no guidance in place for staff to follow to help keep the person, and staff, safe if a person became upset or aggressive. A member of staff said in relation to one person, "It can be scary going to [person's name] if you've never been before. [New staff] need more information." The same member of staff said, in relation to another person, "[Person's name] needs are complex. The plan has not got any detail." This left people and staff at risk as staff did not always feel they had enough information to safely support people if they became agitated.

Some people needed support to mobilise. We were made aware of incidents that had caused injuries to people, as a result of poor moving and handling techniques used by staff. In another example, information in one person's care plan and risk assessment stated the person was hoisted. However, staff told us the person was not hoisted but was supported with alternative equipment. When we asked the registered manager about this they said the person had never been hoisted. This meant the guidance for staff was incorrect and had not been updated to reflect the person's changed need. This left the person at risk of experiencing unsafe or inconsistent care. The same person had experienced an incident where they had slipped out of their wheelchair. Staff had recorded this but no action had been taken to review the person's care or risk assessment to provide guidance how to avoid this reoccurring. This left the person at risk of injuring themselves if they continued to slip from the wheelchair.

We could not be sure that people were always having their medicines as prescribed. One person was prescribed 'PRN' medicines, which means 'as and when required'. There were no instructions for staff about how they would know when the PRN medicine was or was not required. Instructions for staff about who administered this same person's medicines were also not clear. This left the person at risk of unnecessarily experiencing symptoms of their health condition as they may not always receive their PRN medicine when required. It also left them at risk of having the medicines when it was not needed. The instructions for another person were also unclear. It was not clear whether family or staff should be giving the person their

medicines. When we asked the registered manager about this they explained that a family member would leave the medicines out for staff to give to the person. However, staff should only administer or prompt medicines when they can verify they are prescribed and are from the original pharmacy packaging. This meant the person could be at risk of errors being made and the provider could not be assured that only prescribed medicines are taken by people.

Records relating to the administration of medicines, Medication Administration Records (MARs) were also not always clear and there were not always clear instructions for staff. For example, one person's notes state staff should only provide medicines on certain calls. It did not specify which medicines this referred to. However, the MAR showed medicines were being applied on all calls. Staff also told us that best practice was not always followed when information was being added to the MAR charts. Some staff told us that the previous month's MARs were used as a template as well as checked what prescribed medicines were present in each person's home. However, some staff told us they only used the previous month's MAR as a template. This meant changes to people's medicines would not always be identified which left people at risk of not always having their prescribed medicines.

Staff understood their responsibilities to recognise and report abuse, and they knew how to report suspected abuse. We also saw examples of incidents that had been referred to the local safeguarding authority. However, some issues which put people at risk of harm, such as missed calls, had not always been identified and reported as necessary. The provider had failed to recognise their own failings and the level of risk they were exposing people to. They had failed to make changes in a timely manner so lessons had not been learned, following areas of concerns being identified by the local authority. Care plans and thorough risks assessments had not yet been implemented and systems to review the quality of people's care had not been effective. This had continued to place people at risk to their health and well-being.

The above constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not always effectively deployed to ensure everyone always got their planned care at the time needed. We were made aware of multiple calls where staff did not turn up to support people. One relative said, "There have been occasions when no staff have turned up at all. The last time it happened no one appeared, and we rang the office, they said there would definitely be someone at the next call, so we waited and no one came." Another relative said, "We have had missed calls, no one came to do the next call and then the next day they came late to do my relative's tea call." Another relative commented, "This morning's call was an hour late and last week and the week before we had calls of an hour and a half and an hour and 40 minutes late. They don't always let us know so we're a bit stuck. We get excuses like it's car trouble but more often than not it's because they are getting carers to cover extra calls." Staff confirmed there were missed calls. One staff member said, "Missed calls happen regularly. The communication is the issue. The calls might be moved and staff not told." The service used a system where staff logged into a system using a phone within each person's house they would record the time they arrived and left. We found nearly a third of calls were unlogged so it was not possible to tell how many calls had not taken place compared to calls that had just not been logged. This meant we could not always be sure that people were being kept safe by staff attending every required call.

People and relatives also told us that staff were not always attending within a reasonable time and were not always informed about this. Staff told us they found it difficult to get to some of their calls on time as they would also be driving around other staff that may not have a car to be able to get to their calls. One staff member said, "I have to drive other staff [at the same time as having to complete own rota] and it makes both of us late." Another member of staff said, "If I'm with a non-driver calls are late. I have to drive to my

own calls and another carer's calls. It gets stressful like that" and they went on to say, "They ask me to pick up extra calls and it puts me behind." Another member of staff said, "Rotas can be a bit higgledy-piggledy. There are changes and I have extra calls added on." Staff all told us they felt the travel time between some calls was unrealistic and that sufficient travel time had not been built into the rotas to enable staff to be on time.

The above constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not always recruited safely. We saw that some pre-employment checks had taken place, such as seeking references and checking if staff had a criminal conviction with the Disclosure and Barring Service (DBS) to ensure that staff were of a suitable character to work with people having support from the service. However, we found that appropriate action had not always been taken when information of concern was identified. For example, one staff member had declared they had a conviction and this had been checked. However, no record was made of the convictions, when they occurred and no assessment had been made to ensure the member of staff was suitable to work with people. Also, no additional measures had been put in place to ensure the safety of the people using the service. When the service had made a check with the DBS, the service was told there had been an error by the DBS which they said the service had to follow up on to ensure they had the most up to date information about the staff member. This had not been done, despite them being made aware of it. A member of staff had carried out checks to ensure that staff had DBS checks documented within their recruitment file; however, they had identified that some staff did not have one present and they were still working.

The local authority also shared with us that when they visited to carry out a quality monitoring visit, they found a member of staff had declared information of concern, but there was no evidence this had been followed up to ensure the staff member was of suitable character to work with people who used the service. Some staff did not always have two references from previous employers or character references. We saw that some action had been taken to try to get further references, but no mitigating action had been taken prior to any outstanding references being received to ensure people were kept safe until staff suitability had been verified. This meant people were not always kept safe as the service had failed to sufficiently verify and take action to ensure staff suitably to work with people who used the service was appropriate.

The above constituted a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from the risk of cross infection. People and relatives told us staff wore personal protective equipment (PPE) when necessary. One relative told us, "They always wear gloves and aprons." Staff told us PPE was readily available for them to access to ensure it was used during calls.

Inadequate

Is the service effective?

Our findings

At the last inspection this key question was rated good. At this inspection we found the quality and safety of the service had deteriorated and it was now rated as inadequate.

People, relatives and staff told us the training for staff was not always sufficient. One person told us, "Some staff are better than others and know exactly what to do. However, I don't seem to have those at the moment. I have to be telling them all the time". Another person said, "Some of the carers are alright but not others. Some are lacking in understanding of what needs to be done." One relative said, "Some staff just don't seem to understand what dementia is and how it can affect people living with dementia." Another relative said, "It isn't always the same carers who come. Sometimes they send people who don't know what they are doing." A member of staff told us, "As a company they should train us. I've not had any training about behaviour that challenges but I most definitely would benefit." Training records showed that staff did not always have their training updated in a timely way. The monitoring of staff training was not always effective as it was not easy to verify that all staff had received all mandatory training and when staff were due to be re-trained. We were told that new training was being developed, partially in response to feedback received by the service from people and their relatives. However, people were left at continued risk as they felt, as well as relatives and staff, that staff were not sufficiently trained and records confirmed this.

There were supervisions in place however there was mixed feedback about how supported staff felt. One staff member said, "The management could listen more and be more understanding." Another staff member said, "Supervisions are not especially useful. We didn't discuss a lot. It was a tick box exercise. There wasn't enough feedback about how I was performing." Some staff felt their concerns were not always responded to. One staff member said, "I don't always feel supported. If I try to get in touch when I'm in the field they don't always answer. I've called the office several times and don't get a response. It's dead frustrating."

The above constituted a breach of Regulation 18 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw that decision-specific assessments about whether people could make decisions about their care were not being carried out. Decisions made in people's best interest were not recorded and it was not possible to see who was involved in decisions about people's care and how decisions were made in people's best interests, in line with the MCA. When we spoke with the Business Development officer about this they told us of a new form which had been designed however this had not been implemented, despite us being told it had been available for a number of weeks prior to our inspection. This meant the service had not fully considered people's capacity to make decisions about their care and insufficient action had been taken to remedy this.

A person who has Lasting Power Of Attorney (LPOA) for health and welfare has the legal right to make decisions and sign agreement on behalf of someone who has lost their capacity to make their own decisions. We saw multiple examples where relatives or representatives had signed consent on behalf of people, however their legal right to do so had not been verified. This meant the principles of MCA were not being applied and people's rights were not always protected.

The above constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who needed to support to eat were not always protected. For example, one person was at risk of choking. There was no risk assessment or guidance about how to ensure the person stayed safe. When we asked a member of staff involved in supporting this person if there were any risks about choking they said, "Not as far as I know." This meant some staff were not all aware the choking risk and there was no guidance for them to follow which put people at risk. The same person also had minimal guidance for staff which said the person should have a 'soft diet' however there was no further detail about what a 'soft diet' should consist of. When we checked with another social care professional they explained that guidance from a Speech and Language Therapist (SALT) had changed to a normal consistency diet, but this had not been updated in the person's risk assessment. Other people told us they were supported to have food and drinks and that staff offered people a choice and that staff presented the food nicely.

We saw that referrals were made to other health professionals however we found that professional advice was not always incorporated into people's plans. For example, one person had guidance from an Occupational Therapist (OT) about what equipment to use to help the person move. Staff had not followed this guidance as the care notes where staff recorded what they assisted the person with on each call showed different equipment was used. The OT later re-assessed the person and provided specific guidance about how the person should be supported which was put into the person's property for staff to follow. However, prior to the re-assessment the person was left at risk of receiving inconsistent support.

Some people had specific health conditions. For example, some people had diabetes. Staff were not expected to test some people's blood sugars, however there was no guidance available for staff and staff did not always know how to respond or what symptoms to look for if a person was hypoglycaemic or hyperglycaemic. When a person experiences a hypoglycaemic (low blood sugar) or hyperglycaemic (high blood sugar) episode, immediate action can be required to prevent a person from becoming more ill. Some people may also not be able to communicate if they were felling unwell. In another example, another person could experience seizures. There was no detail about if there were any triggers that could cause a seizure, how a seizure presents itself and what action to take in the event of the person experiencing a seizure. One member of staff we spoke with who visited the person was sure what to do. Another person needed oxygen which they could manage themselves. However, staff told us they would help the person, the staff member said, "I help them. I turn it up and down." There was no risk assessment or guidance in place for this. This meant people were at risk of not being supported appropriately which could put their health and well-being at risk.

Inadequate

Is the service caring?

Our findings

At the last inspection this key question was rated good. At this inspection we found the quality and safety of the service had deteriorated and it was now rated as inadequate.

People and relatives felt positively about some of the staff that visited them, however some people did not always have a consistent team of staff. One person said, "It is not normally the same staff that come; I wish it was though. We used to get the same but not now. I like the same as you get to know one another." Another person said, "I have three regular carers and usually the tea time carer does the evening call. It does get more difficult when you get new ones though as I don't know them and I have to direct operations more". One relative said, "It is not normally the same staff and my relative has dementia so it can be very confusing. One carer has been pretty regular, and they are very good with my relative, but some just don't understand my relative's condition". Another relative said, "We get a lot of different carers. It would be ideal to have more regular ones, but they swap and change them from time to time." This meant some people were not always able to build up trusting relationships with the staff that supported them in order to ensure they always had quality care.

People and relatives did not always feel listened to and did not always feel they had choice and control over their care. One relative commented, "It feels like we're just a number." A relative told us of an incident where a member of staff said something inconsiderate in front of a person. This made the person "angry and upset." There were some comments about the conduct of the office staff. Another relative said, "I had to speak to [office staff] on numerous occasions and they don't listen, they talk over me and they try to say it's my relative making stuff up." This meant some staff were not always considerate towards some people. People did not always receive their care at the time they expected which people found frustrating. Some people did tell us they were always told if their carer was going to be late, but others were not always told. This left people concerned about where staff were. One person told us, "Staff don't come on time and don't always let me know if they are going to be late." A relative said, "The times are terrible. They don't always let us know either [if staff are going to be late]."

The above constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite some issues, some people and relatives felt the staff did treat them with kindness and respect and helped to stay independent. One person said, "The staff are all very nice people. They are gentle with me and never rush me. They are helping me stay independent." Another person said, "The staff are very good, they are all very nice people." Other comments included, "The staff are nice with me, we talk about anything really" and, "The staff are all very caring, content people who come. We work together; I am more than happy with everything that is set up."

Inadequate

Is the service responsive?

Our findings

At the last inspection this key question was rated requires improvement. At this inspection we found the quality and safety of the service had not improved and people's experience of their care had deteriorated and it was now rated as inadequate.

There was not always up to date information available for staff to be able to support people effectively and people and relatives told us this could sometimes be a problem. One relative said, "If they are new I have to tell them what to do and it is tedious as it all takes time and they are not here long as it is. Staff don't always look at the care plan folder which doesn't help, in fact thinking about it I don't recall them ever looking at it before they start the call." Another relative said, "There is a care plan, but it really needs updating. The main carer we have says it all needs updating though, so I'm really not sure which information they are working off. To be honest not a lot of the carers read the plan beforehand." Another relative commented, "I think the care plan is by social services; it is very explicit although I wonder if all the staff read it. I don't recall anyone from MSC sitting down with us to go through everything." Another relative said, "The care plan is from social services [no MSC care plan was in place] and really needs updating." Staff also told us that plans did not always contain enough detail. One staff member said, "I don't think they're [plans] particularly good. Some are out of date and don't reflect needs and not specific enough."

The local authority, also called social services, provided the service with plans which contained basic details about people and the type of support they required. However, the service should then develop a more detailed plan of care and associated risk assessments to ensure people had the opportunity to comment upon how they liked being supported. One staff member said, "In previous companies I've worked at, there would be a comprehensive plan detailing exactly what is needed [at each call]. But here they just use the council plans as its more work otherwise." This meant the service had failed to develop personalised plans of care for people so staff did not always have sufficient detailed and up-to-date information about people. For example, one person had a risk assessment in place for moving and handling, but this had not been updated despite staff supporting the person in a different way to what was detailed on the risk assessment. There were no personalised details about how people preferred to be supported, for example with personal care or the particular food and drinks people liked. This meant people may not always be supported consistently and in a way they liked.

Timely action was not always taken when a person's needs had changed. For example, one person was putting themselves at risk by trying to cook before staff arrived, as their call time was not at their preferred time. A member of staff said, "I feedback time changes [about the person] but it hasn't made a bit of difference." The service had failed to take action to try and change the call time to a time more suitable one for the person, which meant the person continued to put themselves at risk by attempting to cook meals.

The above constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people felt their feedback was not always listened to a dealt with or they could not always get hold of

office staff to discuss their concerns. One person said, "I don't really know how to complain." One relative said, "They [staff based in the office] say they will look into it but don't get back to us." Another relative told us, "I can never get through to the office, it rings for ages. I spoke to social services about the issues as I couldn't get hold of anyone from MSC". Another relative commented, "I had to ring the out of hours number and nobody answered." One person who had complained said, I've not had any outcomes to my complaints, not been contacted for any input and not heard anything." A social care professional said, "When we have raised concerns these have been met with defensiveness and agreed actions have not been carried out." We saw that when people made a complaint that an investigation took place to ascertain what happened and to help identify any actions required. However, documentation regarding complaints was not always clear and it was not always possible to see what the initial complaint was regarding. Therefore, it was not always possible to verify the correct action had been taken and that concerns were fully responded to. There was a complaints procedure in place; however, this did not include details of where else people could complain if they did not want to complaint to the service, or if they were unsatisfied with how their complaint was dealt with. A new 'Service User Guide' had been introduced which included further information about other organisations; however, the complaints procedure had not yet been updated.

The above constituted a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not support any people who required palliative care who were nearing the end of their life.

Inadequate

Is the service well-led?

Our findings

At the last inspection this key question was rated good. At this inspection we found the quality and safety of the service had deteriorated and it was now rated as inadequate. There was poor oversight of the quality of care being provided.

People, relatives and staff did not always feel the service was well run. One relative said, "I would recommend the staff but not the company as I think it is lacking organisation." Another relative said, "It's at the top [management] that something needs to be done. If they're not doing their job properly, how can they expect the carers to?" Another relative said, "I don't know if I would recommend them [the company], probably not unless they can sort out the issues regarding timing and understanding of my relative's condition". One member of staff said, "There is a lack of communication. One person [office staff or manager] says one thing and another says something different." Another member of staff said, "There's too much work to do [with paperwork and improvements] but not enough staff to do it." Staff told us there weren't any staff meetings. One staff member said, "We don't get staff meetings so we don't get to communicate together." A member of staff also described the management as, "Orchestrators of chaos." Another social care professional said, "The service has seemed disorganised and communication has been inconsistent" and went on to say, "I do not feel there has been effective partnership working." This meant people and relatives did not always have confidence in the ability of the management team to effectively run the service.

Some people knew who the registered manager was; however, some people did not. One person said, "I don't know who the manager is and who to speak to if I was worried about anything." Another person said, "I don't know who the manager is." A relative said, "I don't know who the manager is. No one from the company has rung me to discuss anything. I go through social services." Another relative said, "The manager doesn't like to speak to service users so it seems. They are always in meetings and even though [the care coordinator] will say they'll get the manager to ring us back they never do. It can be very frustrating…" Another relative said, "I've phoned on numerous occasions and not once has the manager got back in touch." This meant people and relative did not always feel there was effective communication could not always discuss their concerns.

The local authority had visited the service to carry out a quality monitoring visit to check people were receiving quality care. Their visit found that there were concerns about how the service was being run and about a lack of oversight. The local authority gave the service an action plan to follow with deadlines of when to have completed some of the areas which needed improvement. Prior to this visit, the service had failed to recognise that their current risk assessments and lack of care plans meant staff did not always have enough information to effectively care for people. When we asked the registered manager about the lack of care plans and guidance they said, "We introduced new paperwork but that hasn't worked so we've learned. It's our fault."

However, at our inspection we found many of the same concerns that the local authority found and insufficient improvement had been made against the action plan. When we fed back to the registered

manager, they said, "Everything you have said, we are working on." One relative said, "They seem to be very slow at reacting to things." A member of staff said, "I think they want to supply a top class service. But I think they are struggling. I think they are struggling with the amount to do." For example, it had been identified by the local authority that people did not have care plans in place and that risk assessments were not always sufficient. We also found this to be the case and four weeks following the feedback from the local authority, only one care plan had been developed. The service had failed to prioritise which people needed guidance and assessments putting in place, due to their health conditions or other risks associated with their care. This had left people exposed to the risk of harm as insufficient and speedy action had not been taken to remedy the omissions in the guidance for staff.

Systems and processes for identifying concerns and improvements required were ineffective. There had previously been no auditing systems prior to the local authority visiting the service. The registered manager said, "We're behind on audits." Processes implemented since receiving feedback had not been effective at identifying concerns. For example, care notes and MARs were audited by staff. One person had not had their prescribed topical cream for an entire month, as staff had not recorded it as applied and staff had not explained why it was not applied. The MAR had been audited and this had not been identified as an action to look into further. Another person's care notes had information about an incident where the person was found on the floor by staff and paramedics were called. These care notes had been audited and this had not been identified. There was no record of this on the provider's electronic system and no action had been taken following this incident to reduce the likelihood of a reoccurrence or determining the potential cause. Systems had also failed to identify the incident so it could not be considered as part of the monitoring of accidents and incidents. Another person's care notes had been audited which showed differing advice from an OT and that staff were not always following that advice. This meant issues that needed further consideration were not being identified by the new systems being put in place which meant people's experience of care was not always being improved.

Systems to identify missed calls, prior to them occurring, were not always effective. One relative said, "What I don't understand is the staff have to book in when they arrive so why is no one monitoring the system which would tell them the call has been missed. It seems a pointless exercise to have the system and not utilise the information". A member of staff said, in relation to missed calls, "They [office staff and management] wouldn't know immediately, they need to be proactive rather than reactive." The registered manager explained that they had employed additional staff to check the monitoring system and check with staff if they had attended calls. However, there was a large volume of calls whereby staff had not logged in and out of a call, which would make it difficult to check each one. The service relied on people or relative's identifying late or missed calls which put some people at risk as some people may not be able to summon assistance if necessary.

There was a lack of coordination between the management team. A member of staff said, "There is a lack of communication between the management team so staff suffer." For example, the Business Development officer would develop new documentation, but no one would take the lead on testing or implementing the new documentation. We were told, in relation to new mental capacity assessments, "I have no idea where anyone has got from trying it" and, "They've [the assessment] been available for weeks but not been implemented." This meant timely action was not always taken to implement change to improve the quality of care for people.

The above constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Notifications were being submitted. The previous inspection rating was also being displayed in their office

and on their website, according to the law.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People and relatives felt the quality of care was impacted upon a lack of staff knowledge and understanding about what was required. Staff felt personalised information about people needed updating.

The enforcement action we took:

Notice of Proposal to cancel registration

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People experienced care that did not make them feel like they were treated with dignity and respect. Some and relatives were upset with interactions they experienced with staff.

The enforcement action we took:

Notice of Proposal to cancel registration

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights were not being held as the service had not fully considered or implemented the principles of the Mental Capacity Act 2005. People did not have their capacity assessed and representatives were signing agreement on behalf of people without their legal right to do so being verified.

The enforcement action we took:

Notice of Proposal to cancel registration

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care

	and treatment People did not have risks to their health and well being assessed, planned for or managed. We could not be sure people were always having their medicines as prescribed.

The enforcement action we took:

Notice of Proposal to cancel registration

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Despite a complaint system being in place, people felt like they were not listened to and did not always receive feedback about their concerns.

The enforcement action we took:

Notice of Proposal to cancel registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of oversight of the service. Timely action was not always taken following feedback. People and relatives struggled to get in touch with management or office staff in order to discuss their feedback. Systems implemented were not effective at identifying concerns. There was a lack of coordination between the management team.

The enforcement action we took:

Notice of Proposal to cancel registration

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Information of concern regarding staff was not always followed up on and the assessment of risk to people had not been done if staff had a conviction on their DBS. Measures had not been put in place to protect people until the suitability of staff had been verified.

The enforcement action we took:

Notice of Proposal to cancel registration

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing

People were not always receiving the care they required. Staff did not feel their rotas were achievable.

The enforcement action we took:

Notice of Proposal to cancel registration