PHC Home Care Limited

PHC Home Care Limited

Inspection report

Systems House
246 Imperial Drive
Harrow
Middlesex
HA2 7HJ

Date of inspection visit:
10 April 2018
17 April 2018

Date of publication:
05 September 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

PHC Home Care Limited is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults living in the London borough of Harrow.

At our previous inspection in January 2018 we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to risk assessments, staff training, care plans and quality monitoring. During this inspection we found that some improvements had been made in relation to these breaches. However, we identified further failures to meet the regulations.

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

Prior to this inspection CQC had received intelligence from external sources, including professionals, raising concerns for the safety of the people receiving care from PHC Home Care Limited. We considered these concerns as part of our inspection.

The leadership and management of the service was inadequate and placed people at risk of harm.

Risks to people had not always been identified and managed appropriately. We found that care workers did not always have the information they needed to deliver safe care and treatment to people. Although we found that some care plans had been updated since our last inspection, there remained a failure to ensure that these reflected potential risks identified elsewhere in people's care documents.

The service did not have sufficient numbers of care workers to meet people's needs. People had consistently received late or missed calls. Chances for improvements were limited because the service did not learn and make improvements when things went wrong. Similar incidents had continued to occur because the service did not monitor calls on a routine basis to make sure they were completed.

The service did not have clear systems to keep people safe and safeguarded from abuse. At our last inspection of the service we found that there was no evidence that new care workers had received training in safeguarding of adults at risk. At this inspection the training records showed that these staff members had still not received up-to-date safeguarding and safety training appropriate to their role. Furthermore, care workers with previous cautions or convictions had continued to work with people even though risk assessments had not been completed.
The provider did not show us that they had enough money to keep the service going.

There was no evidence of learning, reflective practice and service improvement. Whilst there was an internal

audit system in place, we found this to be unreliable and irrelevant because shortfalls were either not addressed or identified. This meant we could not be assured that the audit process was effective.

At our previous inspection the provider was unable to demonstrate that care workers had always received the training and support that they required to ensure that they were competent in their roles. This had remained the case at this inspection.

Even though people told us care workers were caring, the concerns we found at this inspection did not demonstrate a caring approach. The provider was unable to demonstrate that new care workers had always received the training and support that they required to ensure that they were competent in their roles. This meant they may not have been sensitive to the needs of people.

At the last inspection we found that people's individual care needs assessments did not always include information about their personal needs and histories. Information contained in the assessments that was relevant to people's care was not always included in their care plans.

At the last inspection we found that the system of responding to complaints was not operating effectively. This continued to be the case at this inspection. People told us they had raised concerns regarding late or missed visits and these had not been addressed satisfactorily. We saw no evidence that concerns were dealt with appropriately and any learning implemented to improve the service. This was also true of complaints from care workers, which we saw had not been addressed by the service. This meant we could not be sure people's and staff's views were considered or that complaints were acted on in line with the service's policies.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection we met with the provider on 11 May 2018 asking what action they had taken to address the concerns raised. Following the meeting they provided us with information and evidence of the action taken to address some of the concerns raised. However, we were not reassured the provider will be able to meet its financial commitments and therefore to provide care to people. We were not assured that the issue relating to staff shortages would be resolved. We took this information into account when deciding what action we took. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for the service from this inspection is 'Inadequate' and therefore the service is continuing 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, it 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 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

Please note that the summary section will be used to populate the CQC website. Providers will be asked to share this section with the people who use their service and the staff that work there.

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 had not always been identified and managed appropriately. There were no risk assessments in relation to the administration and management of medicines.

The service did not learn and make improvements when things went wrong. Calls were not being checked on a routine basis to make sure they were completed.

The service did not have clear systems to keep people safe and safeguarded from abuse. There was no evidence that new care workers had received training in safeguarding of adults at risk.

Two care workers' Disclosure and Barring Service (DBS) checks noted previous cautions or convictions but no risk assessments had been carried out to establish if the care workers posed any on-going risk to the people who used the service.

Is the service effective?

Requires Improvement

The service was not effective. There was no evidence that some staff had received training before commencing work with people.

Consent was sought in line with the principles of the Mental Capacity Act 2005 (MCA).

People were not always supported to maintain their health and wellbeing.

Although people's needs had been assessed by the service, their needs were not always met.

Is the service caring?

Requires Improvement

The service was not always caring.

Relatives told us staff were kind and caring. However, the provider had failed to address matters which had been raised at previous inspections. People had continued to be at risk.

Individual communication needs had been assessed. This enabled care workers to communicate with people in the way they needed to. However, this needed to be tailored to the specific requirements of Accessible Information Standard (AIS).

Is the service responsive?

Requires Improvement

The service was not responsive. Care plans used did not always include information relevant to people's care and support.

People told us that staff shortages at the service were affecting their care. This was because people ended up receiving care from care workers who were not aware of their needs.

At the last inspection we found that the system of responding to complaints was not operating effectively. This continued to be the case at this inspection.

Is the service well-led?

Inadequate

The service was not well led.

The leadership and management of the service was inadequate and placed people at risk of harm. We established action was not always taken to improve or mitigate risks.

The provider could not demonstrate to us that they had enough money to keep the service going.

Even though the provider had known since 2017, that they were in financial difficulties, in April 2018 they had still not drafted a recovery plan.

The provider did not effectively assess, monitor and improve the quality and safety of the service provided.

PHC 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 was prompted in part by information we had received about the quality of care and financial concerns about the service. We brought forward our planned comprehensive inspection.

This inspection took place on 10 and 17 April 2018, and was unannounced on the first day. The inspection team consisted of two adult social care inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience made telephone calls to people and relatives. She spoke with nine people.

Prior to the inspection we reviewed information we held about the service, including notifications, previous inspection reports, the provider's recovery plan, safeguarding and quality assurance reports and feedback from the London borough of Harrow. A notification is information about specific events, which the service is required to send us by law.

We spoke with the registered manager, nominated individual and seven care workers. We looked at 20 care records for people receiving care from PHC Home Care Limited. We also looked at personnel records of eleven care workers, including details of their recruitment, training and supervision. We reviewed further records relating to the management of the service, including staffing rotas and quality assurance processes, to see how the service was run.

Inadequate

Is the service safe?

Our findings

At our previous inspection in January 2018, we rated the provider as 'inadequate' under the key question of 'Is the service safe'. At this inspection we found the provider was still inadequate.

The service did not have adequate systems to assess, monitor and manage risks to people's safety.

At our previous inspection, in January 2018, we found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Individual risk assessments did not always contain information in relation to potential risks to people. For example, where care workers supported people to take prescribed medicines, the recording of this was unclear and risk assessments had not been carried out.

At this inspection we found that care workers did not always have the information they needed to deliver safe care and treatment to people. Although we found that some care plans had been updated since our last inspection, there remained a failure to ensure that these reflected potential risks identified elsewhere in people's care documents. For example, the care plans for two people stated that they required prompting with their medicines and that care workers should ensure that they "keep medicines out of [the service user's] sight" However, there was no information in their care plans or assessments to indicate why this should be the case nor were there any risk assessments in relation to administration and management of medicines.

Similarly, the care file for another person who received support with catheter care and requiring two care workers to assist with moving and handling did not include risk assessments or risk management plans in relation to these tasks. Also, the risk assessment of another person showed they were at risk of developing pressure ulcers. Their care plan stated that staff must 'monitor for any signs of bed ulcers on pressure areas', however, no other information was available detailing what precisely to look out for. Another care plan contained the following information, 'ensure that her air mattress is working and inflated according to her weight'. There were no further instructions for staff. One more risk assessment stated that one person was at risk of dehydration, with instructions, 'make sure [this person] is not showing any signs of dehydration'. It did not state the dehydration signs for staff to look out for.

The service did not learn and make improvements when things went wrong. This inspection was prompted in part by a notification that the service was experiencing staff shortages, due to some staff having terminated their employment owing to unpaid wages. As a result, from speaking with people receiving care and care workers, we learnt that a significant number of people had experienced late or missed calls since our inspection of the service in January 2018, increasing in April 2018. We checked to see how late or missed visits were recorded and analysed to prevent similar incidents from occurring. The management told us that they operated an IT system to monitor visits. The system was meant to monitor attendance by recording and relaying the times care workers entered and left calls. However, we found that calls were not being checked on a routine basis to make sure they were completed. For instance, out of many late or missed calls that occurred between October 2017 to April 2018, only one late call had been recorded as an incident.

Furthermore, this had not been analysed. Therefore, from our discussions with the provider, similar incidents had continued to occur.

This demonstrates a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people if their care visits were ever missed or late. People and their relatives told us that care workers did not always arrive at the same regular time. Their comments included, "Sometimes care workers did not turn up or arrived late", "Last week care workers were not turning up until the afternoon when they should be here between 9am-10am", "A few weeks ago it happened and it was every morning for a few days" and "The agency started off alright, but they went downhill. They could do with a jump start."

During our inspection, we identified that most people had been affected by this. We found that during the period between January 2018 and April 2018, the service had failed to ensure that people continued to receive a safe and reliable service.

We found that one person had failed to receive two out of four care visits and had to rely on a family member to provide care. We also saw from records that this had become a regular occurrence of late. This person was bed bound and needed assistance with all aspects of personal hygiene. The person was noted to be at high risk of dehydration and malnutrition, falls and prone to pressure ulcers. Their care plan stated, 'regular turning at regular intervals to prevent skin breakdown from pressure injury.' Another person received two calls per day. These calls were for domestic assistance, personal care and prompting with medicines. The person was also noted to have complex needs. We received confirmation from care workers that this person had received a late visit on 10 April 2018. This experience was also a common occurrence for most people using the service, who also had complex care needs.

All this showed that the service did not have sufficient numbers of care workers to meet people's needs. There were no rotas kept, which meant we could not review staffing over a period of time. However, the management and staff confirmed that the organisation was experiencing staff shortages. For example, we spoke with some care workers who were called at short notice to attend to people, where their regular care workers were not available. They confirmed with us that they had arrived to provide care hours later than the normal scheduled time. They further explained that this had affected all the other calls they were due to make on that day. This shows the service was failing to keep people safe by meeting their needs.

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

At our inspection in January 2018, we also found that the provider was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to carry out adequate checks of the suitability of staff members prior to their employment. References and criminal records checks (DBS) had not always been obtained.

During this inspection we found that the provider had taken some steps to address these failures. The service had started to carry out appropriate staff checks at the time of recruitment. However, the service had not addressed concerns from our last inspection relating to two care workers, who had previous convictions noted on Disclosure and Barring Service (DBS) checks. We saw that the service had still not undertaken any risk assessment to establish if the care workers posed any on-going risk to the people who used the service. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. Therefore, by

not carrying out risk assessments on the respective care workers, the service was not safeguarding people from abuse.

Furthermore, the service did not have clear systems to keep people safe and safeguarded from abuse. At our last inspection of the service we found that there was no evidence that care workers who had been recruited since September 2017 had received training in safeguarding of adults at risk. At this inspection the training records showed that these staff members had still not received up-to-date safeguarding and safety training appropriate to their role.

This demonstrates a continuing breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in January 2018, we rated the provider as 'requires improvement' under the key question of 'Is the service effective'. At this inspection we found the provider still required improvement.

At our previous inspection of PHC Home Care Limited in January 2018 we found that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was unable to demonstrate that staff members had always received the training and support that they required to ensure that they were competent in their roles.

During this inspection we found that no further evidence or information was available to demonstrate that all care workers had received training to ensure that they had the skills that they required to support people. There remained no evidence that care workers who had commenced working at the service since September 2017 had received training to support them in their roles. Files contained Care Certificate self-assessments completed by care workers. However, there was no record that any training had been carried out to support this, nor were there any certificates or other records showing that care workers had undertaken or completed a course of study to achieve the Care Certificate.

At our previous inspection the registered manager told us that new staff members 'shadowed' more experienced staff prior to working with people. However, they did not provide evidence that this had taken place. During this inspection we found that, although such records were in place for longstanding care workers, there remained no evidence that 'shadowing' had taken place for care workers recruited since September 2017.

We asked to see a system of quality assurance for the performance of care workers. The management told that us they carried our regular spot checks. However, there was no evidence to show us that such checks were being carried out. Such checks would have been a way for the service to gain assurance that care workers were providing care to people safely and in accordance with care plans, or to check that care workers were turning up on time and carrying out the full range of required tasks.

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

People's needs had been assessed by the service before they started to use the service. Assessments covered areas such as nutrition, moving and handling, communication, health and safety, and relevant medical conditions. Care plans included guidance about meeting these needs. As part of this, the service worked with a range health and social care professionals to ensure people's needs were met.

People were involved in their care. Their choices were recorded in care plans. People told us that care workers asked for permission before carrying out any care. They told us that they were involved in making decisions about their care. One person told us, "Care workers ask me how I like my coffee." Another person said, "We went through a new care plan. They asked me what I needed." A third person said, "When they first

came we told them what we wanted." People's capacity to make choices had been considered in line with the Mental Capacity Act 2005 (MCA).

The 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.

People's choices were recorded in care plans. There was a record of people's preferences and requirements in relation to a range of areas including eating and drinking and personal care. People's care plans reminded staff to ensure that relevant procedures were explained to people and consent obtained before carrying out care.

People were supported to have sufficient amounts to eat and drink. People's care plans contained detailed information about food and drink. For instance, care plans instructed care workers to ensure people had adequate food and drink prior to living. They reminded care workers to ensure 'drinks were within easy reach'.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in January 2018, we rated the provider as 'good' under the key question of 'Is the service caring?'. At this inspection we found the provider required improvement.

People receiving care told us their dignity was respected. Their comments included, "Care workers respect my dignity. They are very pleasant" and "My dignity is respected." A relative said, "Care workers are respectful. They change the bedding and keep my relative clean and safe." Another relative told us, "The care workers would do anything for my relative."

Care plans prompted care workers to always treat people with respect and dignity. For example, staff were reminded to ensure bedroom curtains were drawn to provide privacy. Care workers confirmed they ensured people were covered up during personal care. They told us they kept doors closed and curtains drawn when they were delivering personal care.

Even though the feedback relating to care workers was positive, the concerns we found at this inspection did not demonstrate a caring approach. People had continued to be at risk related to medicines and other conditions such as pressure ulcers and dehydration. Furthermore, the shortage of care workers meant that they may not have had enough time to get to know people and offer them compassionate support. The provider was unable to demonstrate that new care workers had always received the training and support that they required to ensure that they were competent in their roles. This meant they may not have been sensitive to the needs of people.

Individual communication needs had been assessed. For example, the care plans of people with dementia advised staff of ways to communicate. Equally, other information was provided to people in an easy to read format. This enabled care workers to communicate with people in the way they needed to. However, this had not been tailored to the specific requirements of Accessible Information Standard (AIS). As of 1 August 2016, providers of publicly-funded adult social care must follow the AIS in full. Services are required meet people's information and communication needs.

At our previous inspection we found that the service tried to match people with care workers according to culture, language and interests. However, at this inspection due to staff shortages, this was much more difficult to maintain. This was echoed by people we spoke with. They told us that they no longer received care from regular care workers.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in January 2018, we rated the provider as 'requires improvement' under the key question of 'Is the service responsive?' At this inspection we found the provider still required improvement.

At our previous inspection of PHC Home Care Limited in January 2018 we found that the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's individual care needs assessments did not always include information about their personal needs and histories. Information contained in the assessments that was relevant to people's care was not always included in their care plans.

At this inspection, some care plans we viewed provided detailed information regarding people's care needs and how care workers should support them. The plans for a person who required support with foot care and another person with swallowing difficulties included detailed guidance for care workers on the actions that they should take to support people in meeting their needs. Care plans for people with communication difficulties associated with dementia also included information for care workers on how they should support people to make choices.

However, we also found that not all care plans provided appropriate information to enable care workers to support people effectively. We found that care needs assessments had not yet been updated to include information about people's care needs and histories. We found that the needs assessments for people were not always included in their care files. The registered manager told us that these were being updated following our last inspection but we were not shown any evidence of this. Where needs assessments were contained in people's files, these had not been updated since our last inspection.

Although some people's care plans had been recently reviewed and updated, we found that these did not always reflect information contained elsewhere in their files. For example, a care needs assessment for a person which was carried out in December 2017 indicated that they sat for long periods and were at risk of pressure ulcers. Their care plan was updated during March 2018 but made no reference to this, nor guidance for care workers on how to reposition or otherwise support them to reduce the likelihood of pressure ulcers.

We asked people what happened to the care they were supposed to receive if calls had been missed. People's feedback included, "I take medicines in the morning. However, recently I have not been getting it in the morning as care workers were turning up late "and "I take medicines in the morning. Unfortunately, I am not able to get dressed on my own, so I'm lying in bed until care workers arrive." Some relatives also expressed similar concerns. A relative told us, "My siblings and I are around most of the time. If we were not around, it would be a total disaster. Medicines and feeding would be an issue."

People told us that staff shortages at the service were affecting their care. The staff shortages meant there was lack of forward planning resulting in people receiving care from care workers who were not aware of their needs. One person told us, "My care worker is good. However, they change over so much. Some carers could do with some training as they do not understand the care that I normally receive." A relative told us, "If

the agency was more punctual and stopped changing the care workers all the time, then care would be better."

This demonstrated a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found that the system of responding to complaints was not operating effectively. This continued to be the case at this inspection. We found that people were aware of the complaints procedure. However, some people told us they had raised concerns regarding late or missed visits and these had not been addressed satisfactorily. The concerns that people told us they had raised were not recorded as complaints and there was limited evidence these issues had been acted on. People's feedback included, "I phone the agency if they are late. It is usually 'Leave a message and we'll get back to you on the answerphone', but they don't call back. Sometimes I had to talk to them about my needs but they do not take it on board", "They never call back" and "Something needs to be done about lateness and lack of response from the office." A relative said, "I leave notes around for the care workers and they respond to it. However, I do not get anything back from the office. All they say is 'We will get back to you', and they don't." Another relative said, "I do not know who to contact in the office. I have not even got sheets to say who's been in. This happens from time-to-time. I am a bit concerned about that."

We saw no evidence that concerns were dealt with appropriately and any learning implemented to improve the service. This showed people's views and experiences were not always considered in the way the service was provided and delivered in relation to their care.

This was also true of complaints from care workers, which we saw had not been addressed by the service. We spoke with the provider about this and they told us they were addressing the concerns. However, we saw no evidence to support this. This meant we could not be sure people's and staff views were considered or that complaints were acted on in line with the service's policies.

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

Inadequate

Is the service well-led?

Our findings

At our previous inspection in January 2018, we rated the provider as 'inadequate' under the key question of 'Is the service well-led?' At this inspection we found the provider was still inadequate.

In January 2018 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because systems and processes were not operating effectively to monitor and improve the quality of the service. During this inspection we found the provider had still not addressed these issues.

The leadership and management of the service was inadequate and placed people at risk of harm. The registered manager and the nominated individual did not demonstrate to us that they understood the challenges that the service was facing in relation to lack of financial resources. This was the third inspection of the service since it was re-registered with The Care Quality Commission on 14 August 2015. The provider has been in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at all three inspections. Whilst some improvements had been made in some areas, the financial situation had not improved. At our second inspection in January 2018, we reported of our lack of confidence in provider's financial viability to continue to provide the service as set out in their Statement of Purpose. At this inspection, we found the concerns were still on-going. The provider could not demonstrate to us that they had enough money to keep the service going.

Where shortfalls had been identified, we established action was not always taken to improve or mitigate the risks. For example, even though the provider had known since 2017, that they were in financial difficulties, in April 2018 when we visited the service they had still not drafted a recovery plan. Consequently, in April 2018, the service had not responded effectively to its financial situation. During our inspection we asked the service to send us a recovery plan by 12 April 2018. This was received on 17 April 2018 but did not contain sufficient information, demonstrating the leadership did not have oversight of the scale and nature of the work required to address concerns regarding their financial status as well as the day to day operational issues. Eventually, the provider sent an improved draft. The provider informed us that they were reducing the number of people they provided care to. This was part of the financial recovery plan, making it easier for the provider to provide care with their existing care staff complement. However, the provider did not provide us with documentation that demonstrated that the proposal improved their financial viability.

Furthermore, the provider told us that their financial position was such that they needed to apply for a Company Voluntary Arrangement (CVA). The CVA allows a company with debt problems or that is insolvent to reach a voluntary agreement with its business creditors regarding repayment of all, or part of its corporate debts over an agreed period of time. On 10 April 2018 the provider told us that the initial application had been put on hold because of late payment of fees required to process the application. On 17 April 2018 the provider told us they were sending a copy of the CVA application to the Commission on 19 April 2018 but we did not receive this. On 20 April 2018 the provider wrote to us stating they would update us during the following week. We again asked the provider about this when we met with the registered manager and the nominated individual on 11 May 2018. They told us that they were to make a final payment

on 18 May 2018 for the processing of the CVA and that they would provide the Commission with a copy of the submitted CVA by 21 May 2018. This has not been received to date.

Therefore, we were not assured that the provider had a clear financial arrangement in place or that the arrangements to address the financial situation were viable or transparent. There is a risk that the provider will not be able to meet their financial commitments and therefore not be able to provide care to people.

The above evidence shows a breach of Care Quality Commission (Registration) Regulations 2009 (Part 4) Regulation 13: Financial Position

This was also true of other non-financial matters. For example, following the January 2018 inspection the provider sent us an action plan which detailed the actions they were to take to improve the quality of audit systems and the target dates for completion. This included an undertaking to carry out risk assessments for care workers with criminal convictions on their Disclosure and Barring Checks (DBS). This was to be completed by the week commencing 5 March 2018. However, at this inspection on 10 and 17 April 2018, we identified that the provider had not acted to address these shortfalls.

The leadership was not always open and transparent. There were concerns relating to care workers' salaries. We asked the registered manager and the responsible person to provide information relating to care workers who were owed money but this was not provided. Care workers told us that the leadership of the service were not being open regarding the unpaid salaries. One care worker told us, "I am owed a lot of money. I have not been told the truth about when it will be paid." Seven other care workers shared a similar view and their comments included, "I was paid last Friday. This was after a number of weeks without pay" and "I am not sure when I will be paid next."

Most care workers did not feel valued, respected and supported by the leadership. Care workers we spoke with told us they were afraid to raise concerns in case they were not paid their owed salaries. One care worker told us, "There is no point of putting so much effort in a place that I am not so appreciated." Another care worker said, "If it wasn't for our supervisor a lot of staff would have left. She always let others get paid before her."

There was a lack of systems in place to enable learning and improvement of performance. For instance, we found that some care plans had been updated since our last inspection, however there had been only a very limited improvement in their quality. There remained a failure to ensure that the system of updating care plans and risk assessments reflected potential risks identified elsewhere in people's care documents.

The provider did not always maintain accurate, complete and contemporaneous records relating to care delivery. We found that people's care records were not being audited. This demonstrated the provider was not working in accordance to their policy. Therefore, there was a risk that people would receive care and treatment which was not appropriate and did not meet their needs.

There was no clarity around processes for managing risks, issues and performance. We found that the leadership did not have oversight of safety alerts, incidents, and complaints. The management told us the service relied on an electronic monitoring system to relay information about late or missed calls. However, we found the system to be ineffective as no incident reports had been recorded regarding late or missed calls even though we had been notified of recent occurrences. This meant the leadership did not have overall oversight of the issues that were affecting the smooth operation of the service.

The system for recording complaints or issues was also ineffective. No complaints had been recorded at the service, even though people had spoken about concerns. The provider did not have a system in place for analysing and learning from complains received. We saw no record of discussion relating to complains to ensure they were handled appropriately and any learning identified.

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

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 9 HSCA RA Regulations 2014 Person-centred care Information contained in the assessments that was relevant to people's care was not always included in their care plans. As a result the service was not always meeting people's needs.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have adequate systems to assess, monitor and manage risks to people's safety.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service did not have clear systems to keep people safe and safeguarded from abuse.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The system of responding to complaints was not operating effectively. We saw no evidence that concerns were dealt with appropriately and any learning implemented to improve the service