Lakeside Care Services Limited

Alexios

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 inspection took place on 25 and 26 July 2017 and 02 August 2017 and was unannounced on the first day. Alexios was previously known as Carewatch – Bolton. In January 2017 the service changed its name to Alexios. There were no changes to the nominated individual who was also the registered manager.

The last inspection took place on 21 September 2016 and was rated as Requires Improvement. There were five breaches of the regulations in relation to person centred care and assessment , safe management of medicines, dealing with and responding to complaints, inadequate record keeping, training and development and staff supervisions.

At this inspection we found very little improvement had taken place from the last inspection and continual breaches of the regulations in respect of person centred care, medication, complaints, governance, staffing provision and staff training.

There was a registered manager in place who was also the nominated individual. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. There was also an office manager in post supporting the registered manager. There was no evidence to show that the registered manager had oversight of the management of the service. There was no evidence to show when the registered manager was in the office. The management arrangements were not satisfactory. The governance of the agency and ensuring that it provides a good quality of care in a safe and consistent manner to service users is lacking. Regulations where breached at the last inspection and despite the Provider submitting a plan of action to the Commission to address these breaches the service remains in breach. The action plan had not been addressed.

Some people we spoke with told us they felt safe with their regular carers who visited them; however many did not feel safe at times when unknown care staff came to their house. There were numerous missed calls and late visits which had the potential to seriously impact on the health and wellbeing of service users.

There were insufficient staff to cover the work load given and staff we spoke with told us they were not able to get to calls on time which resulted in late or missed calls. We saw for one person who had eight visits a day that on 22 July 2017 records showed there had been only six visits, on the 24 July 2017 only two visits were recorded and on the 02 August 2017 we saw that the 14.30 visit for medication was 40 minutes late. This meant that medicines were not being in a safe and timely manner and people's health and safety were at risk.

Medicines systems were unsafe. There were gaps in the recording on Medication Administration Records sheets (MARs) and time specific medication had been given late or missed and this placed people at significant risk of harm.

There was safeguarding policy in place. Staff spoken with had not received up to date training in safeguarding or the Mental Capacity Act 2005 (MCA). This meant that staff may be unaware of how to recognise different types of abuse and the ways they can report concerns.

Environmental and personal risk assessments were not undertaken to help ensure the safe delivery of care and use of equipment. Staff had not undertaken appropriate infection control training. This meant that staff were not aware of assessing risk of, and preventing, detecting and controlling the spread of infection.

There was a staff induction book for new staff to complete on commencing work. The training record was not thorough and essential training and specialist training had not taken place. This meant that people were being cared for by staff who had not had learning and development to enable them to fulfil the requirements of their role.

Care records held in the office and in people's homes were incomplete and did not include relevant health information for example allergies, names of GPs were found to be missing and there was no list of current medication in the support plan. There was some evidence of consent for issues such as medicines administration from the local authority; we questioned the viability of the agency's consent forms and mental capacity assessments which had been ticked as being completed. There was no evidence of a mental capacity assessment form or who had completed the assessment. The service was not working within the legal requirements of the Mental Capacity Act 2005 (MCA).

We saw from care records that some reviews of care had taken place. These were basic and lacked detail. Care plans were not person-centred and did not include a range of health and personal information. Assessments were not thorough and the registered manager had not listened to people's preferred preference of a male or female carer.

Confidential information was not locked away safely in the office. Information was stored in boxes around the ground floor of the office.

There was a service user guide which should have been given to all people who used the service and/or their relatives. There was no evidence seen in the care files in people's homes to show this had been received.

There was a complaints procedure in place. The service had received a number of complaints, some had been responded to, however there were no records of discussions with staff concerned. There was no monitoring of complaints by the registered manager that would enable them to identify trends and patterns and address the complaints accordingly.

There was an out of hour's service for people who used the service and staff could also access help and guidance if they required it via the out of hour's number.

Staff meetings were held but there was no evidence of the registered manager's input at these meetings and staff attendance was low. There was no information in the Alexis Careworker Handbook regarding team meetings and the expectation of staff attendance. There was no system in place to evidence how information from these meetings was cascaded to staff.

There was a lack of quality monitoring and assessment of the service. We saw some telephone monitoring calls had taken place and some staff had received spot checks. These were basic checklist and there was no evidence to show how any actions from the spot checks had been addressed.

Recent information/reviews seen in some people's homes was still being recorded on Carewatch paperwork. The registered manager informed us in writing that as from 14 January 2017 that all Alexios paperwork work would be in place within the next three months.

Accidents and incidents were not recorded appropriately or monitored by the registered manager. There was only one staff incident recorded in the accident and incident file.

Providers are required by law to notify the CQC of certain events in the service such as medications errors, safeguarding and other serious concerns. The CQC had not been notified of all such incidents.

Policies and procedures were held electronically, we were informed by the manager that these were under review and it was the intention to have a hard backed copy of the policies in the office.
The recruitment process was sufficient and suitable checks had been completed to help ensure that staff were suitable to work with vulnerable people.

Staff supervision sessions were now being completed. Staff who had been at the company for a number of years confirmed they had never an annual appraisal. The overall rating for this service is 'Inadequate' and 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.

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

Arrangements for the safe recording and administration of people's medicines was inadequate, so did not ensure people were protected from the risk of unsafe medicines management. Missed calls placed people at risk of not receiving their medication as they should which could impact on them maintaining good health.

Some people told us they felt safe with their regular carers; however they did not feel safe at times when unknown care staff came to their house.

Staff had not undertaken essential training to ensure people received safe and appropriate care.

Is the service effective?

Inadequate

The service was not effective.

Staff spoken with confirmed they had not undertaken annual training as required or any specialist training.

People did not always receive appropriate nutrition and hydration to ensure their health and wellbeing.

Consent forms had been completed and signed, the validity of these was questionable.

Is the service caring?

Inadequate

The service was not consistently caring.

Some people we spoke with told us their regular carers were very good and that their privacy and dignity was maintained but this was not consistent.

Not all staff were caring and they did not always complete the tasks required to ensure people's comfort.

People's wishes and preferences were not taken in to account.

Is the service responsive?

Inadequate

The service was not responsive.

Care and support plans were not person centred and in most case the paperwork was incomplete.

The agency assessments were not thorough to ensure that staff could respond to people's needs and preferences.

Not all complaints were followed up appropriately and actions taken were not recorded. No evidence of action taken, learning or analysis to prevent reoccurrence was evident.

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Is the service well-led?

Inadequate

The service was not well led

There was no evidence to show that the registered manager was in day to day control. The Provider had no quality assurances systems in place which were working effectively to ensure the provision of good quality care to the service users.

There were some basic audits in place; however these had not consistently identified potential shortfalls in medicines administration and gaps in recording of other incidents.

Providers are required by law to notify CQC of certain events in the service such as serious injuries and safeguarding concerns. Not all notifications had been reported to the CQC.

Alexios

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.

This inspection took place on 25 and 26 July 2017 and 02 August 2017 and the first day was unannounced. The registered manager was not available to assist with the inspection. The office manager facilitated the inspection.

The membership of the inspection team comprised of one adult social care inspector and a medicines inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for elderly people. At this inspection the expert by experience undertook telephone calls to people who used the service and their relatives.

Before our inspection we reviewed the information we held about the service. This included the last inspection report and notifications the provider had made to us. We asked the local authority commissioners and the safeguarding team for their views about the service. They did share some information with us.

During the inspection we spoke with eleven people who used the service, five relatives and a person from a local visiting service who was a regular visitor to a person's home. We spoke with six members of staff and the manager and four members of the office staff. We visited five people in their homes. The registered manager was unavailable for the duration of the inspection dates.

We looked at the care records for 14 people who used the service and medicines administration records for nine people. We also looked at the recruitment, training and supervision records within five staff files, minutes of meetings and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

We spoke with people who used the service, staff and relatives. One relative told us, "The service is appalling. The standard of care provided by some carers is awful. They [agency] are going to kill someone". We were provided with several examples of poor care from this relative including, staff leaving the front door unlocked on numerous occasions all night and missed visits that resulted in their relative being left sat in a chair all night. One member of staff reiterated that the agency at times were putting people at significant risk of harm by missed and late calls, missed medication and a lack of staff training. Two people who used the service told us they had requested that male carers did not attend to their personal care needs and this had been disregarded, one person told us, "They [agency] sent me a male carer, I don't want a man helping me to undress, this meant that this person was left at risk of struggling to undress and get themselves into bed which was very difficult and would potentially place this person at risk of falling. Another person said, "They [agency] sent a male carer for my night visit, I did not know who he was, I went to my door and this man was stood there in a 'bob' hat, it was very frightening". A relative told us, "I am terrified of going on holiday in case the carers do not turn up and my [relative] is left without calls". One person who used the service told us, "I feel safe with [main carer] she makes me laugh". Another said, "I'm not safe with some of them [carers], I thought if I was ill whatever would I do". For another person the records showed that on 27 and 30 May 2017 and, 5, 6 and 9 of June 2017 the person who used the service cancelled the calls when they saw a male carer had been sent. On the 9 June 2017 the person told the carer to leave or they would call the police.

We saw a letter from a friend that had been sent to the agency raising concerns about a missed call. The letter stated that on 04 February 2017 no carer visited for the 21.30 visit, contact was made with the "on call" person who said they would contact the team, 22.55 caller rang again and was told the carer was on their way, 23.55 no carer, caller rang again and eventually at 00.00 on the 05 February 2017 the caller rang for help from the district nurse. The person made a formal complaint to the service about this lack of provision. The office manager could not provide us with evidence that this complaint had been responded to. The office manager thought there may be something on the computer; however we were not shown evidence of this. There was no record of a response to this complaint in the complaints file.

On 20 March 2017 we saw for another person there was no visit on the Saturday morning and a late visit on Sunday 21 March 2017. On the 30 April 2017 information showed visits were missed, the times of the calls were too close together and there was no indication to show that medication had been given at the appropriate times required. There were numerous examples of other missed or late calls. This meant that people were left at risk of harm. Missed and late calls should have been flagged up on the electronic monitoring system in the office and should be addressed by the registered manager as part of their quality monitoring.

We looked at how the service ensured there were sufficient numbers of staff to meet the needs of people who used the service. From the information provided by the agency we saw that 77 members of staff were employed and the service was providing care to 165 people whose care had been commissioned by Bolton Local Authority and 22 private packages. There were numerous care packages where multiple visits were

required. Staff spoken with said they were not enough staff employed to meet the needs of all individuals receiving support.

We looked at five staff personnel files. We saw that new staff had been recruited and interviewed by the manager. Information in the staff files included: an application form, written references and other forms of identification for example, a copy of the applicant's driving licence or passport. We saw Disclosure and Barring (DBS) checks had been undertaken. A DBS check helps to ensure that people are suitable to work with vulnerable adults and children.

We saw that care staff had access to protective clothing such as disposable gloves and aprons to help protect from and prevent the spread of any infection. Care staff could collect these from the office as and when required.

We were told there were policies and procedures in place; however we were informed that these were currently under review. Polices were kept electronically and when reviewed there would be in a hard backed copy for staff to refer to. We did see evidence of the safeguarding and medication policy. Staff spoken with were unaware of where policies and procedures were kept.

We found that people were not protected from the risk of abuse as there was no evidence of updated safeguarding training. Staff spoken with confirmed they had received no refresher training or updates since their basic induction on commencing work.

At our last inspection we found that medicines were not safely managed. At this inspection we saw medicines were still not managed safely and people's health was at risk of harm. A pharmacist, medicines inspector, looked at medication records kept in the office for nine people and looked at records and medicines for four of those people in their own homes, together with medicines for another two people in their home.

The information recorded about how each person's medicines should be managed did not contain enough information to guide staff how to support people with their medication safely. There was no record of what medicines people were prescribed. We saw that there was confusion about one person's medicines and the carer told us she had to visit the pharmacy in her own time to make sure they gave the correct medication, because it was so confusing. Another person had medication in their home which was not on the current medication recording sheets so it was unclear if they were receiving the correct medication. There was no information recorded about how medicines should be stored in people's homes to ensure people were not put at risk of harm. We saw from the records in the office that one person has brushed their teeth with Ibuprofen gel, which the manufacturers state if swallowed a doctor or hospital must be contacted. We looked at the daily logs for a married couple who both lived with dementia. It stated the husband's medicines were locked away so he could not take them in error but his wife's medicines were not locked away and the care staff recorded that the husband had given the medicines to his wife, and on occasion had taken her medication by mistake. This placed both of them at significant risk of harm. Following our inspection the relative of these people said the regular carer had since purchased a separate locked box to store the husband's medication. This was not reflected on the office support plan.

We saw that people who needed to be supported with their medication had a range of different medical conditions and most of those people were also living with differing levels of memory loss and dementia. Two people took medication to alleviate the Parkinson's symptoms. This medication is prescribed as 'time specific'. It is vital for medicines for Parkinson's need to be exact in order to be effective we saw that the times of their visits were not planned properly which meant that they did not receive their medication at the

times it was needed. We saw that on some days they missed having doses of their medicines, including antibiotics, because their calls were missed. On some days this person tried to take their own medication which meant that there was not a safe interval between doses.

We saw that one person chose to administer some of their own medication. Another person, who was confused and had limited vision, had medication left out for them to take later in the day because they did not have a call at the time they needed their medication. A third person was frequently recorded as taking their own medication before the carers arrived. No risk assessments had been completed to show it was safe for these people to take their own medicines.

The medicines administration record sheets (MARS) were full of gaps, missing signatures and it was impossible to tell from these records if people have been given all their medication properly.
Some people were prescribed medication to be given with a choice of dose or when required. However their support plans failed to record that they were prescribed any "when required medicines". There was no information recorded to guide staff how to administer medicines prescribed in this way.

There were no arrangements to give medicines which needed to be given before food. We saw that carers recorded they had given these medicines with or close to breakfast which meant the medicines may not work properly placing their health at risk of harm.

We were also informed that for one person where pain relief patches were prescribed that care staff did not remove the old patches and kept putting another patch on. This person was found with four old patches in place. This could have been detrimental to this person's health.

These findings evidenced a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Five people who used the service told us they were happy with their regular care staff who knew how to undertake the care tasks and provided a good standard of care. However some people and their relatives did not have the same confidence. One relative spoken with told us they had booked a holiday and were so relieved to hear that the regular carer would be on duty whilst they were away. The carer was highly praised for her care and commitment provided to their relative.

One person told us, "I have the same lady every time unless she is on day off. I choose not to have anyone else. They are lovely ladies but I choose to have the same one".

A second person told us "I get breakfast orange juice and bran flakes and tea. The carer has a coffee and a chat with me. This is good. Another carer made breakfast six months ago, I showed her to put the milk in pan put in microwave to warm it up and to give me half a glass of orange juice. When it came the Weetabix was cold, tea was cold and I had a full glass of orange juice. It is murder in the mornings if my main carer isn't coming, the times vary and if it's a different one it is chaotic".

A third person told us, "The carers are not well trained only the regular carers. One girl, I can't understand a word she says. The first time she came I asked her to do one thing and she said she wanted to do something else, for example make tea I told her I had had my tea, she said she would change the bed so my husband gave her a sheet. When I couldn't find the dirty sheet we looked and she had put it on top of the dirty one. I asked her to put my voltarol (cream) on; she went to the cupboard and brought back paracetamol. I had to explain I wanted voltarol cream putting on my legs. She said I will give you your tablet I told her I take my own. She doesn't write her name in the book and needs lots of training. I rang and asked them not to send her again. She came again yesterday, I have rung today at 8.45 am there was no answer I will ring again to tell them I don't want her". This was discussed at feedback with the office manager who told us that the registered manager commented, "This person would complain as they only want their regular carer".

We asked the office manager about staff training. We were told the registered manager deals with the training programme. We saw the registered manager had a 'train the trainer' qualification in moving and handling as had three other members of staff. There was some evidence that some staff had undertaken moving and handling recently and had received medication training from a pharmacist.

We saw little of evidence of training certificates in the staff files we looked at. However some of the staff spoken with confirmed that they recently had undertaken moving and handling and medication refresher training. This was the only training staff had completed there was no evidence of other training such as safeguarding awareness, first aid, food hygiene, infection control, mental capacity or dementia awareness. There was no specialist training for diabetes, supporting people on oxygen, Parkinson's or catheter care despite staff providing care for people with these care needs. This meant that people were being cared for by staff who had not been suitably trained to carry out these tasks.

These findings evidenced a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

We asked one relative how staff supported their relatives with nutrition and hydration. The relative told us that as part of the care tasks staff should lay the table for their relative so when meals on wheels arrived they could place the meal on the table. This prompted the person that their meal was there. On five occasions this year the table has not been set and the meal was left in the kitchen, therefore the person had forgotten to eat it. As these meals are not reheatable they had to be thrown away and the person had gone without a hot lunch. This was not acceptable as this person was reliant on carers completing the tasks in the support plan to ensure this person was prompted to eat their meals. The relative told us that they had contacted the office and raised these concerns on several occasions and had a written log of these concerns which they shared with us.

Another relative told us that care was provided for both relatives of whom one was type one insulin diabetic. We were told by family that prior to having a recent holiday they had prepared 14 (7 days) cooked tea time meals which were ready for staff to reheat. Instructions regarding this were clearly displayed on the fridge door. On their return only 3 day's meals had been given, snack teas have been provided by care staff. The relative stated this would not have happened if the regular carer had not been on leave. This meant that this person was not receiving a healthy balanced diet at the correct time following their insulin injection which may result in the person suffering from hypoglycaemia (where the blood sugar is lower than normal).

We were also provided with information from another relative that showed one person had missed tea time's calls so no teatime meal was offered. The relative confirmed the office had been informed.

These findings evidenced a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In one care file we looked at the local authority support plan clearly stated that this person was living with dementia. We saw an Alexios consent form in the file stating this person had agreed and signed to give permission for the company to collect personal information for the primary purpose of providing a quality care service. This was dated 17/07/17. We spoke with this person and from our conversation this person was struggling to comprehend our questions and they did not know what the relationship between the relative with us in the home was to them despite seeing them on a regular basis. This called into question the viability of the consent form. We also found similar evidence in another file completed on the same day and this person was also living with dementia.

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). People in their own homes are not usually subject to DoLS. From our discussions with staff they confirmed they had not received training the MCA and DoLS to ensure they were aware of the principles.

On the agency support plans there was a tick box section which asked if a mental capacity assessment had been completed we saw that some were ticked as this had been done. There was no evidence of mental

capacity assessment or who had completed this and whether staff were suitably trained to carry out this assessment.

At our last inspection we saw that staff were not receiving supervision meetings. These meetings provided staff with the opportunity to discuss any concerns they may have and any further training and development needs they may wish to undertake. Staff spoken with said that they now received supervisions. On checking the staff files we saw some evidence of basic supervision records. One member of staff told us, "I have had supervision, but they [management] won't act on anything you say so there is no point". There was no evidence of annual appraisals for staff who had been at the agency for over 12 months.

Inadequate

Is the service caring?

Our findings

Five people who used the service and relatives spoke positively about their regular carers. One person said, "Every morning when my main carer comes in she is bouncing, full of beans, she is great and I can talk to her and tell her things. My main carer cares, some do not care". Other people told us their carers were "Fantastic", "Lovely and kind" and "Could not manage without them"

A relative told us, "I can't begin to tell you how bad this service is, but for my [relative's] main carer I don't know what I would do, she is excellent. The management and office staff are rude and unhelpful. When speaking with a member of the management team they were antagonistic and certainly untruthful. This was when the relative challenged them about missed medication and a late breakfast call that took place at 11.45 am.

Another relative told us that the care provided at times was 'shocking' they gave an example of their relative's wet bed being made and the soiled bedding not changed. One of the tasks was to ensure that the fire was lit, this did not always happen and the person had been found to be very cold when their relative arrived. This could have had a significant impact to this person's health and wellbeing if it had been in winter months this person could have suffered from hypothermia.

A member of staff spoken with when asked about the service and the care provided told us, "Well I would not use this service to care for my relatives. The way it's organised and managed is poor, in fact it is dangerous. We cannot get to calls on time and there are missed calls and missed medication".

It was brought our attention that at times people's dignity was not always maintained. For example wet bedding and soiled incontinence products left in the kitchen and not disposed of appropriately. When another person was asked about privacy and dignity and respect they told us, "Some [staff] do treat [me] with respect some don't, they are not the caring type and should not be employed".

From our observations there was good staff interaction between people who used the service and their relatives. The people who used the service said they regularly had the same carer who knew them well. Likewise staff confirmed they attended the same people regularly and knew what people wanted. This helped with people's continuity of care. It was apparent that regular carers were good, however these carers were being let down by other care staff who were failing to complete basic care tasks. Problems occurred when main carers were not able to attend due to holidays or sick leave. People who used the service and their relatives were genuinely worried about the lack of care provided by some carers.

Inadequate

Is the service responsive?

Our findings

Our findings

We received mixed views and opinions on the service. One person who used the service told our expert by experience that one carer visited her home and used inappropriate language and swearing. This was reported to the office; however there had been no response or communication of actions taken. We did not see evidence of this complaint in the complaints file. A relative told us, "A few weeks ago I told them [office] a carer's skills needed polishing up and I told them we didn't want certain carers and now they send them all the more. It is because they are short staffed. People who we got used to have left and more are leaving every day. Another person told us, "The main carer writes in the white book [log book], however one carer wrote about my husband watching television and some never touch it [log book] or don't sign it".

One person told us, "At the beginning the office staff went through all the care plan. She filled in a book and even asked if the appliances in the house were working OK. We went through lots of things and I signed a few forms".

The care and support plans we looked at contained very basic information to guide staff on the care and tasks to be provided. Care plans were not person centred and in most cases the paperwork was incomplete.

We did not see a copy of the complaints procedure within their documentation in the home. This was in the service user guide which should be available to all people who used the service.The procedure we saw in the service user guide also gave people the contact details of other organisations where they could take any concerns further if they wished including the Care Quality Commission (CQC) and Bolton Council. From discussion with people who used the service and their relatives it was apparent that concerns and complaints had been raised with the agency, however these were not all documented in the complaints file.

People spoken with stated they would feel comfortable to raise a concern or complaint at Alexios if necessary. However, those who had complained felt their concerns had not been addressed. There was no evidence from the agency to show they had taken the complaints seriously and resolved them and applied any lessons to be learnt from them.

These findings evidenced a breach of Regulation 16 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see that the service had received some compliments cards, one praising carers for the way they completed their notes and another thanking the office staff for sending a lovely carer to look after their relative.

We saw that the local authority when commissioning a care package completed and sent to the agency a support plan. It is the responsibility of the agency to then complete their own service assessment. The assessment should cover all aspects of a person's health and social care needs and the information was

used to help form the plan of care. We found the agency assessment process was poor and the assessments did not ensure that the agency staff could meet people's needs and that people who used the service benefitted from the placement.

These findings evidenced a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

As part of our inspection we spoke with people who used the service, relatives and staff to ask their views and opinions about the service. One member of staff described the organisation of the service as 'shambolic'. We were told, "The organisation is poorly managed. There are not enough staff to cover calls especially at the weekend. There are some good carers who are genuinely worried about the care that some people receive. There are missed calls and people do not always get their medicines on time".

Another member of staff told us, "People are not getting their calls on time; dinner time visits are running in to the tea time visits which have a 'knock on' effect with medicines. Records are not checked by management, if you report something through it is not followed up". Another member of staff thought things had improved since the arrival of the office manager they found her supportive and helpful.

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

None of the people who used the service nor the relatives with whom we spoke knew who the registered manager was. All provided us with the name of the office manager. The staff we telephoned following our inspection also confirmed they thought the office manager was the registered manager. One member of staff told us, "I have never seen the owner; I thought [name] was the registered manager.

There was no record to show when the office manager or the registered manager where in the office. Therefore we were unable to assess the time spent at the office by the registered manager or by the office manager. It is a requirement that the person who is registered as the manager is in day to day control of the service and is accountable for the service provision. The Registered Manager may delegate tasks to others such as the manager but he cannot delegate his responsibilities and remains accountable for the delivery of the care. The Registered Manager needs to consider how he can demonstrate to the Commission that he is available in the office and is in day to day control of this service.

We saw that some staff supervisions and staff meetings, recruitment and complaints had all been completed by the office manager although actions following complaints with staff had not been recorded. There was also personal information regarding a member of staff in the complaints file on a piece of notepaper that other staff apart from management had access to. Therefore confidentiality was not respected.

There was no evidence to show that the registered manager had attended any team meetings from when the minutes were recorded from February 2017 to date. From the minutes of the meetings we looked at these were poorly attended by staff. We asked the office manager how people who did not attend meetings were kept up to date with what had been discussed. There were no systems in place for the management to check that care staff had read the minutes of what had been discussed at the meeting. The Alexios

Careworker Handbook does not provide staff with details about team meetings, whether they are expected to attend and is this in their own.

We discussed with the office manager that the registered manager had the responsibility to manage and support all staff and to ensure that care was being delivered appropriately. It was evident from discussions with staff and people who used the service and from the information we looked at the presence of the registered manager was limited.

We asked the office manager what systems were in place to monitor and assess the quality of the service. We saw evidence of some telephone monitoring checks. There were mixed responses from people who used the service. One person commented, "Happy with the care received, no cause for concern. Another comment stated, "No visits last two Mondays. Few late calls and visit cancelled with no notice due to visits being late and passed few months have been hit and miss, people don't arrive on time".

We received information that the registered manager had confirmed the office manager would not have access to certain systems in the office. As the registered manager was due to be absent for most of August 2017 the office manager would have limited access to information. This meant that that the registered manager had left the agency without providing the office manager with suitable access to information.

The agency had an electronic call monitoring system in place. This showed the time carers had arrived at the home and when they had left. The office manager could not provide data on missed or late calls.

We saw that some 'spot checks' had been completed by the senior carers. This was to check that care staff were carrying out the tasks required and provided people who used the service and their relatives with an opportunity to speak with senior staff. These spot checks were a basic tick box exercise and there was no record that the registered manager or the office manager had audited these checks or carried out any of the spot checks themselves. The records in peoples home clearly identified where there had been issues with care.

We found that there were no systems in place to review and analyse care plans, medication, missed visits and late calls, accidents and incidents and complaints. This lack of quality assurance of the service has placed people at risk of not receiving the right care at the right time which impacts upon their health and wellbeing.

This is a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities).

Providers are required by law to notify the CQC of certain events in the service such as medications errors, safeguarding and other serious concerns such as missed calls .The CQC had not been notified of all such incidents. This failure to notify is a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration).