Care & Connect Solutions Ltd

Care & Connect

Inspection report

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15 September 2017
18 September 2017
19 September 2017
21 September 2017
22 September 2017

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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

The inspection was carried out on 15, 18, 19, 20, 21 & 22 September 2017. The first day was unannounced. We gave notice of the other days because we needed to be sure someone would be in the office to assist with the inspection and we needed consent from people who used the service and family members to visit their homes.

Care & Connect is a domiciliary care agency, providing personal care and support to people living in their own homes. The service operates from an office based in St Helens, close to the town centre. There were 41 people using the service at the time of our inspection.

The service has a registered manager who is also the registered provider. They were registered with CQC in October 2016. 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 carried out an unannounced comprehensive inspection of this service in April 2017 and found that the registered provider was not meeting all the requirements of the Health and Social Care Act 2008 and associated Regulations. We asked the registered provider to take action to make improvements to the recruitment of staff, records, and assessing, monitoring and improving the quality and safety of the service. We received assurances from the registered provider that all actions had been completed. However at this inspection we found that the registered provider had not met these legal requirements and we found further breaches of the Health and Social Care Act 2008.

Prior to this inspection we received concerns from members of the public about staff recruitment, care and welfare of people and the leadership of the service. We looked at those concerns as part of this inspection.

The required improvements had not been made to ensure the safe recruitment of staff. Recruitment of new staff was not always safe and thorough. The required checks were not always obtained for staff employed. There were no recruitment records for one member of staff including evidence of a check on their criminal background. References checks obtained for some staff employed did not correspond with their previous employment history and gaps in employment history for staff employed were not explored. The lack of robust recruitment checks put people at risk of receiving care and support from unsuitable staff.

The timeliness of visits to people's homes was poor. We found multiple examples were visits to people's homes were late; some were late in excess of two hours. This resulted in people not receiving the care and attention they needed at the right times putting their health and safety at risk.

Risks which had the potential to cause people harm had not been assessed and mitigated. One person had complex needs, however no risk assessments had taken place to determine the level of risk for the person

and others, and how they were to be managed to keep the person safe.
Accidents and incidents had occurred however they were not appropriately reported and recorded. In addition no action had been taken to analyse the incidents as a way of looking at ways of reducing the risk of further occurrences. This exposed people to the risk of harm.

The management of medication was unsafe putting people at risk of harm. There were no protocols in place to guide and instruct staff on the use of 'as required' medication (PRN), this was despite the registered provider's medication booklets stating that a specific plan for administration of PRN medication must be recorded. Some people did not receive their prescribed medication because the stock had run out and because of the poor timeliness of visits. One person did not receive pain relief because the medication was unavailable and another person received pain relief over two hours late due to poor timeliness of visits.

People did not have their needs met by staff who had received the right training and support for their role. Upon appointment staff completed induction training based on The Care Certificate, a nationally recognised qualification for health and social care workers. However staff were not provided with training specific to the needs of people. Some people required end of life care and catheter care however staff had not received any training around how to deliver this care. No checks had been carried out to check on staff competence in relation to practical tasks they carried out such as moving and handling and administration of medication.

Staff felt unsupported by the registered manager/provider. They told us that the registered manager/provider was difficult to contact. Staff supervisions had not taken place to assess and monitor their performance and training and development needs. This was despite the registered provider's policy stating that staff would receive supervision within the first three months of employment and on a regular basis thereafter.

People were not always treated with respect. People were left waiting for long periods of time for staff to attend their homes and on many occasions they were not contacted to be notified of the late visit. This unsettled people and caused them unnecessary anxiety. People often did not know which staff were visiting them, and they found it difficult to establish trusting and positive relationships with staff because of the high turnover and inconsistency of staff.

Complaints received were not listened to and acted upon. We were made aware of a number of complaints made to the registered manager/provider about the service. However no action was taken in response to the complaints made. The registered manager/provider confirmed to us that they did not maintain a record of complaints made. This was despite their own policy stating that all complaints including verbal complaints must be dealt with, recorded and investigated.

People did not receive care which was responsive to their needs. One person's care need requirements had not been planned for despite them having a variety of complex needs. This meant that staff did not have the information they needed to enable them to provide the person with the right care. A family member told us that they were unaware of a care plan for their relative and neither of them had been asked to sign one.

The required improvements had not been made to ensure effective systems were in place to assess, monitor and improve the quality and safety of the service. People who used the service, family members and staff lacked confidence in the leadership of the service. They were unsure about the management structure and staff felt unsupported by the registered manager/provider. There were no audit systems in place to assess, monitor and improve the quality and safety of the service. This resulted in the registered manager/provider failing to identify and act upon serious issues that we identified.

Following the visit CQC took urgent action and placed a condition on the registration of the provider to ensure that they do not accept any new service users at Care & Connect.

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

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

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 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.

The lateness of visits to people's homes put them at risk of unsafe care and attention.

Recruitment checks did not always fully protect people from unsuitable staff.

Risks people faced were not assessed and mitigated.

The management of medication was unsafe.

Is the service effective?

Inadequate

The service was not effective.

People did not receive a consistent service.

Staff completed an induction on appointment, however they did not complete training specific to people's individual needs.

There was a lack of support for staff to assess and monitor their performance, training and development needs.

Is the service caring?

Inadequate

The service was not caring.

People were not notified when visits were running late.

People's wishes and preferences were compromised by the lateness of visits.

People felt unable to establish positive relationships with staff because of the high turnover and inconsistency of staff.

Is the service responsive?

Inadequate

The service was not responsive.

Complaints received were not acted upon.

People's needs were not always assessed, identified and planned for.

The on call system was unreliable.

Is the service well-led?

Inadequate

The service was not well led.

The registered manager/provider failed to act upon previous breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The system in place for assessing, monitoring and improving the service were ineffective.

The leadership of the service lacked accountability.

People and staff lacked confidence in the leadership of the service.

Care & Connect

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 15, 18, 19, 21 and 22 September 2017, the first day was unannounced. Two adult social care inspectors visited the office on the first two days of the inspection and one adult social care inspector and an inspection manager visited the office on the third day. Two adult social care inspectors carried out visits to eight people's homes at intervals throughout the other two days of the inspection.

During our visits to the office we met with a senior care co coordinator, three care staff, the registered manager/provider and a company director. Throughout the inspection we reviewed a selection of records including care records for 12 people who used the service, recruitment and training records for five staff, policies and procedures and other records relating to the management of the service.

Before our inspection we reviewed the information we held about the service including information which we received from commissioners and members of the public.

Inadequate

Is the service safe?

Our findings

At our last inspection in April 2017 we asked the registered provider to make improvements to people's safety in relation to the recruitment of staff. Prior to this inspection we received concerns from members of the public about unsafe recruitment of new staff. In addition we received other concerns about people's safety. As part of this inspection we followed up on the requirement given at the previous inspection in April 2017 and looked at the concerns we received.

During the last inspection in April 2017 we found a breach of Regulations 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the recruitment of staff was not always safe. During this inspection we found ongoing concerns in relation to the recruitment of staff.

People were not protected by safe recruitment procedures. Whilst reviewing the electronic visit scheduling system on 15 September 2017, the first day of inspection, we noted that a member of staff was added to the visit schedule. The member of staff was scheduled to attend visits at people's homes throughout the day on 15 September 2017. We requested to view the staff member's recruitment file. The care coordinator told us that there was no recruitment file available for the staff member because they had left a couple of months ago. We checked the electronic system and found that the member of staffs last working day was 02 July 2017. The registered manager/provider advised us over the telephone that the member of staff had not left and that they had taken some time out. The registered manager/provider told us that the staff member's recruitment file was available in the cabinet along with all other staff recruitments files. We were unable to locate the file and requested that it be made available on 18 September 2017 for inspectors to review during the second day of inspection.

The recruitment file was not made available to inspectors on 18 September 2017. On 19 September we saw that the staff member was scheduled on the rota to carry out further visits to people's homes during the day and night. During a telephone discussion with the registered manager/provider we again requested the location of the staff members recruitment file. The registered manager/provider told us that the file had been archived and that it could be found in a box kept in the office. We looked in the box and could not find the file. The meant there was no information to assess the staff member's fitness and suitability to work with vulnerable adults. This exposed people to the risk of harm.

Appropriate checks had not been obtained in respect of applicants before they commenced work at the service. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Schedule 3 requires employers to obtain satisfactory information about an applicant's conduct in previous employment and a full employment history, together with a satisfactory written explanation of any gaps in employment. Recruitment records showed checks were not carried out in line with these requirements. For example, a reference had been obtained for a staff member employed from a previous work colleague who was also a friend. This was despite the application form detailing the staff member's previous employer as a point of contact to provide an employment reference.

References obtained for two other staff employed did not correspond with their employment history. We

also saw that another staff employed provided details on their application form of their previous employment history along with details of those who could be contacted to provide references, however there were no references obtained for the staff member. Applications for two staff employed showed gaps in their employment, however there was no explanation for this and it had not been explored. The lack of robust checks on staff employed meant there was no guarantee that they were of suitable character to work with vulnerable people.

This is a continuing breach of Regulations 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were placed at risk of harm by way of not receiving care on time and by the right number of staff. The system for monitoring visits made to people's homes showed that staff had arrived late and on occasions had not stayed at people's homes for the full duration of the visit scheduled. We checked data taken from Malinko, the electronic system which was used for scheduling and monitoring visits to people's homes. This evidenced multiple examples where personal care visits to people's homes failed to take place on the time. The lack of timeliness of personal care visits resulted in people not receiving personal care, meals and medication on time. This exposed people to the risk of unsafe care.

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

Risks to people were not assessed and mitigated. One person was discharged from hospital with a hospital acquired infection. Despite this no assessment had been carried out to identify any risks associated with the infection. The National Institute for Health and Care Excellence (NICE) sets out quality standards that health and social care workers should follow when caring for people with infections to minimise the risk of the spread of infection. The person also had a catheter in place and staff were responsible for monitoring this and ensuring the correct catheter bag was attached at night. However no risk assessment had been carried out to identify any risks associated with this aspect of the persons care. The failure to assess risk and put measures in place to mitigate risk placed people and others at risk of harm.

Incidents that affected the health safety and welfare of people who used the service were not reported to the relevant external authorities/bodies, reviewed or investigated. Prior to the inspection we were made aware that a number of accidents/incidents had occurred. However there were no records of these incidents/accidents and the registered manager/provider was unable to provide an audit trail of them including; any action taken to mitigate further risks to people's health and safety. The registered manager/provider failed to report the incidents onto the relevant agency, including CQC.

Prior to our inspection we received information about a person being admitted to hospital after falling from a stand aid whilst being assisted by staff. We contacted the local authority safeguarding team before we commenced our inspection for clarification as to whether they had been alerted about the incident. We were told that they had received a safeguarding alert made by hospital staff about the incident. On the first day of inspection we requested records about the incident. An office member of staff was unable to find any records other than a message recorded on the system by a senior member of staff on 04 September 2017 which stated; '[name] admitted to hospital Sunday evening due to fall from stand aid'. There were no other records about the incident. This was also confirmed by the registered manager/provider on the second day of inspection.

On reviewing the daily communication records for another person we saw an entry recorded by a staff member on 12 August 2017. The record stated; 'House is a mess, carers from the night before haven't put a

sheet or protector on the bed so the bed is wet through, mattress is stained and wet, food plates left from tea time. Meds were all messed up. Let the on call know about this.' We discussed this with the registered manager/provider during the inspection and requested details of the action they had taken in response to this. The registered manager/provider was unable to provide us with this information and told us that they did not operate a system for recording and analysing accidents and incidents. This exposed people to further risk of harm.

We were made aware about an allegation of abuse which had been raised by a person who used the service against a member of staff. The allegation is currently under investigation by St Helens Safeguarding team. Despite advice provided by the safeguarding team the registered manager/provider made a decision to allow the member of staff to continue to provide direct care to people. The registered manager/provider contacted us following the inspection visit and confirmed to us that their decision to allow the staff member to continue to provide personal care to people in their homes was based on a risk assessment which they carried out and deemed the risk as low. We requested a copy of their investigation and risk assessment to evidence this, however this was not received.

This was a breach of Regulation 12 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management of medication was unsafe. We found examples were people were prescribed pain relief medication to be given 'when required'. This is referred to as PRN medication which people are to be given only when needed. Protocols are required to be in place for the use of PRN medication with guidance and instructions about their use such as what they are used for and when and how they should be given. However there were no PRN protocols in place to guide staff on the use of PRN medication. This was despite the registered providers medication booklets placed in people's homes, stating that a specific plan for administration of PRN medication must be recorded. This meant people were at risk of not being given their medicines safely.

Some people did not receive prescribed medication because stock had run out and some people did not receive prescribed medication on time. One person's medication administration records (MARs) for a period of four weeks commencing on 07 August 2017 recorded throughout that Lidocaine medicated pain relief patches are to be applied each morning, are not available as they have run out and that Salvix dry mouth pastilles (used to stimulate saliva) are unavailable as they have run out.

Another person's MARs for a period of four weeks commencing on 07 August 2017 listed Versatis 5% plaster, used for pain relief to be changed every 12 hours. The MAR stated this is to be applied in the morning and removed at the night visit. On the 12, 14 and 17 August 2017 it was recorded on the persons MAR that the plaster could not be applied as the previous days had not been removed the night before. This exposed people to unnecessary periods of prolonged pain and discomfort and health complications.

We saw an example where one person was not administered pain relief medication because it was not available and an example were another person received their pain relief over two hours late due to a late visit. We also evidenced that pain relief medication was not available for one person because the stock had run out.

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

Inadequate

Is the service effective?

Our findings

People who used the service and family members told us that the consistency and timing of visits were poor. One family member commented that there had been a really high turnover of staff and estimated in excess of 30 different carers in last 12 months. Another family member told us "Consistency of carers very poor."

Prior to this inspection we received concerns about the timeliness of visits to people's homes and a lack of training and support for staff. We looked at those concerns as part of this inspection.

People did not receive effective care to meet their needs. People and family members told us that staff were often late attending visits to people's homes and that staff did not always stay for the full duration of the planned visit. They also told us that there had been times when only one member of staff attended visits when there should have been two. Their comments included; "The timeliness of calls is terrible"; "Generally carers not on time"; "Calls last generally 20 minutes for the 30 minute slots and 30 minutes for the 45 minute slots"; "Regularly receive calls stating they are going to be late. Carers are consistently late."; "They should be here breakfast, dinner and tea, but they never are."; "I've had to help one carer because the second one never turned up."

Staff did not receive appropriate support and training for their role. On appointment care staff completed an office based induction programme prior to them attending visits in people's home. The induction was linked to The Care Certificate (TCC). This is a nationally recognised qualification introduced in April 2015 for health and social care workers. TCC sets out the minimum standards expected of staff so that they have the necessary skills and knowledge in line with current and good practice. However care staff were not provided with training specific to people's needs.

Two staff we spoke with confirmed that they had provided care to people at end of life but had not completed any end of life training. We evidenced that two people required catheter care. The registered manager/provider confirmed that staff providing this care had not received any training in relation to catheter care. The registered manager/provider told us she didn't think staff needed this training and that she did not know where she could source it. This exposed people to the risk of receiving unsafe care.

There was no evidence of any competency checks having been carried out on staff performance in relation to administering medication and moving and handling. We evidenced that medication errors had occurred. For example, one person was administered medication at the incorrect time, a second person did not receive prescribed medication for pain relief because it was unavailable and a third person did not have their pain relief patch applied at the right time because staff had failed to apply it correctly. One person required staff to help them mobilise with the use of a hoist. The person's family member told us; "Some [staff] seem to know what they are doing and some ask how to use it [hoist]". This exposed people to the risk of unsafe care.

Staff did not receive an appropriate level of support. Staff told us that they did not feel supported by the registered manager/provider. They told us that each time they visited or called the office the registered

manager/provider was unavailable. This registered provider had a policy which stated that all staff would be supervised during their three month probation period to assess their performance and following on from that they would receive regular supervisions. Polices set by the registered provider also made a commitment to ensuring staff would undergo spot checks to monitor and assess their performance whilst they were working in people's homes. However, we reviewed the records of staff supervision and found that only one out of 15 staff listed had received supervision. A total of 11 staff listed commenced work at the service since our last inspection in April 2017 however none of the 11 staff had undergone any form of supervision since employment to monitor and assess their work performance, training and development needs. This put people at risk due to not having their needs met by staff that are not suitably competent and skilled.

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

People who used the service were responsible for managing their own health care appointments with the help of relevant others such as family members. However the details of people's GP and any other healthcare professionals were recorded in their care plans. Staff were confident about recognising if a person was unwell and needed support from other professionals. We were provided with example were staff had called an ambulance following a person having a fall.

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 people lack mental capacity to make particular decisions, any decisions 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. In community services, where people do not have the mental capacity to make decisions on their own behalf, an authorisation must be sought from the Court of Protection (CoP) to ensure that decisions made in their best interests are legally authorised. At the time of this inspection no one who used the service was subject to an authorisation made by the CoP.

As part of their induction staff had completed training in the MCA. Staff knew to obtain people's consent prior to providing any care and support. Staff said that they would report any concerns they had about a person's ability to consent.

Inadequate

Is the service caring?

Our findings

People who used the service and family members told us that staff treated people with dignity and respect. However, whilst there were aspects of the service that were caring, we identified areas where a lack of due care and attention was paid to meeting people's needs which impacted upon their health, safety and wellbeing. This also impacted on people's lifestyle, choices for example what time they got up and retired to bed. We also identified examples where due consideration had not been given to ensuring people were able to openly express their views and be listened to. We have reported on these examples further under the safe, effective and responsive domains.

People were not treated with respect. People were left waiting for long periods of time for staff to attend their visits. Some people's morning visits were in excess of two hours late which meant that they were left in bed and without breakfast for long periods. One person who was dependent on staff to assist them in and out of bed told us that they had spent 14 hours in bed because of late calls. Two other people who also were unable to mobilise independently each told us that they were left in bed for over 12 hours because staff arrived so late for their morning visits. The lateness of night time visits meant some people were unable to retire to bed when they wanted to. A family member told us that on one night their relative refused the personal care they needed because they were so tired by the time staff arrived at their home, which was over two hours late.

People and family members told us on occasions some staff had contacted them to let them know they were running late. However others told us that no one had contacted them about their visit being late, which meant they were left waiting and unsure if staff were going to arrive. A family member of one person told us that on 15 September 2017 their relative had a visit scheduled to commence at 20:45 and that at 22:00 a member of staff called to say they were running late and did not know what time they would arrive. One person told us that the lateness of visits really unsettled them and another person told us they were always on edge and frightened, watching the clock for staff to come, as they were often late.

People who used the service and family members told us that the high turnover and inconsistency of staff meant that it was difficult for them to get to know staff and form positive relationships with them. One person told us that there was a really high turnover of staff. They said that their relative had received visits by in excess of 30 different carers in the last 12 months and said it had got even worse since July 2017. One person told us that they would much prefer to see regular staff as it would help them get to know each other and save them having to repeat the same things about how they prefer things to be done. Another person said, "You get to meet someone [staff] who you like and don't see them again because they keep leaving."

People told us that there had been many occasions when staff who they had never met arrived at their home to attend to their personal care needs. People and family members told us they had no concerns about the identify of staff because they wore identification badges, however they said they would have appreciated information about new staff prior to them visiting their home and were possible would have liked the opportunity to meet them.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that when staff provided them with personal care they did it in a dignified way. For example one person's family member told us, "They [staff] always treat [name] with dignity and respect, using towel to cover her when providing personal care. Another family member told us, "They [staff] always treat [name] with dignity and respect."

Inadequate

Is the service responsive?

Our findings

People and family members told us that they had complained about the service but had not heard back from anyone. One family member said, "I have contacted the office to complain and was told the manager would call me back, but she never did," and another family member said, "I have called the office to raise issues."

Prior to this inspection we received concerns from members of the public that complaints were not listened to and acted upon. We looked at the concerns as part of this inspection.

The registered provider failed to respond and act upon complaints received about the service. The registered provider had a complaints policy and procedure which was last reviewed in January 2017. People who used the service and relevant others such as family members told us they were provided with a copy of the complaints policy and procedure. The policy stated that all complaints including verbal complaints must be dealt with, recorded and investigated. The complaints procedure clearly described the steps to be taken for recording and investigating complaints. It also stated that on receipt of a complaint an acknowledgment letter should be sent to the complainant within 5 working days.

Information held by us which we reviewed prior to the inspection showed a number of complaints were received by the registered provider about the service by people who used it and their family members. In addition a family member told us during our inspection that they had made a formal complaint directly to the registered provider about the service on 12 September 2017. Another family member told us they had contacted the office with complaints about the service on a number of occasions and had not received a response. On the first day of inspection we requested a record of all complaints made, including details of investigations and outcomes. The member of staff working at the office was unable to locate the records we requested. We subsequently contacted the registered manager/provider to request the location of complaints records. The registered manager/provider confirmed to us that she did not maintain a record of complaints made. This meant that complaints received were not listened to and acted up.

This was a breach of Regulation 16 of the Health and Social Care Act 2008, Regulated Activities Regulations 2014.

People did not always receive a personalised service which was responsive to their needs and which put them at risk of receiving unsafe care. On 14 September 2017 a visit was scheduled to commence at 08.55 at one person's to assist them with getting out of bed, breakfast and personal care. Two staff attended the person's home at 10.03, one hour and eight minutes late. A second person required two staff to attend their home at 09.00am until 10:00 to assist them with personal care and breakfast. The first member of staff arrived at 10.26 one hour and 26 minutes late and the second member of staff arrived at 11.13, two hours and thirteen minutes late. Records showed that both staff left after 30 minutes. A third person required one member of staff to attend their home at 09.30 until 10.00. One member of staff arrived at 11.08, one hour and 38 minutes late and left five minutes after their arrival. A fourth person required two staff to attend their home at 12.35 to assist them with personal care and lunch; two staff arrived at 14.54, two hours and 19

minutes late.

A family member of one person who used the service told us that their relative had complex needs and required two staff to attend their home four times each day to assist with personal care and moving and handling. The person's family member told us that on 03 September 2017 staff arrived at their relative's home over two hours late for one call.

A second family member told us that on 16 September 2017 staff were late for all four of their relative's visits. They told us that staff arrived one hour late for the first visit, 30 minutes late for the second visit and one hour and 30 minutes late for the third visit. The persons family member told us that they received a call from the office at 22:30 on 16 September 2017 informing them that staff would be another two hours before attending the last visit. The person's family member subsequently cancelled the visit due to the lateness of it.

A third family member told us that staff are constantly late. They told us that their relative is unable to mobilise independently and required two visits each day to help with personal care, one in the morning and one at bedtime. The persons family member told us that on 14 September 2017 their relatives evening visit was 40 minutes late, on 15 September 2017 their visit was 50 minutes late and on 16 and 18 September 2017 the morning calls were attended by only one member of staff when there should have been two staff in attendance.

People's needs were not assessed and planned for. On 19 September 2017 we visited one person at their home; they were accompanied by a family member. The person began to use the service on 13 September 2017 following hospital discharge. The person had a variety of complex needs and required two staff to visit their home twice a day, once in the morning to assist with washing and dressing and once at night to assist to bed and with connecting a night catheter. Despite this there was no care plan in place to instruct and guide staff on how to meet the person's needs. The person's family member told us that no care plan had been discussed with them or their relative. This put the person at risk of receiving care which was not responsive to their needs.

There was an on call system in place at the service so that people, relevant others such as family members and staff could contact a named person for advice and support outside of office hours. The registered manager/provider and other senior staff worked as part of the on call rota. However we were told of a number of occasions when staff had contacted the on call but failed to get a response. On one occasion a member of staff called the on call regarding an incident which had occurred, however they failed to get a response.

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

Inadequate

Is the service well-led?

Our findings

At our last inspection in April 2017 we asked the registered provider to make improvements to their systems for assessing and monitoring the quality of the service and the maintenance of records. Prior to this inspection we received concerns from members of the public about the management of the service. As part of this inspection we followed up on the requirement actions given at the previous inspection in April 2017 and looked at the concerns we received.

People who used the service and family members told us they were unsure about the current management arrangements at the service. They said they were informed that a new manager had commenced work at the service but did not know much about them. Family members told us there had been a decline in the reliability and consistency of the service over the last few months.

At the last inspection of the service in April 2017, we found the registered provider to be in breach of Regulation 17 of the Health and Social Care Act 2008, Regulated Activities Regulations 2014. This was because the registered provider failed to maintain complete and accurate records, assess, monitor and improve the quality of the service and mitigate risks to the health, safety and welfare of people who used the service. During this inspection we found ongoing concerns in relation to records and assessing, monitoring and improving the service and in addition we found other concerns.

There was a lack of clear leadership at the service. We received information prior to the inspection informing us that staff morale was low due to long working hours and poor leadership of the service. We were also told that a large number of staff had left because of this.

There was a registered manager in place who was also the registered provider. Prior to the inspection the registered manager/provider notified us of their intention to step down from their role as registered manager. They told us that they had recruited a new manager in August 2017 and were in the process of supporting them through an induction period. The registered manager/provider was unavailable on the first day of inspection. We met with the new manager for a short period of time however they were unable to provide us with all the information we needed because they had difficulties locating it. Furthermore they were unable to assist fully with the inspection because they were scheduled to carry out visits at people's homes.

Since the appointment of the new manager the registered manager/provider spent little time in the office because they were working as part of the core staff team carrying out visits to people's homes. This coupled with the absence of the new manager due to them also being required to carry out visits meant there was a lack of management oversight at the service. During inspection on 15 and 19 September 2017 the office was managed by one senior care coordinator who had been in post for one week. They had sole responsibility for the management of the office. This included answering the telephone, monitoring and rescheduling visits, updating records and in addition they had staff interviews scheduled. The senior care coordinator supported the inspection as best they could however they were unable to access a lot of the records we requested because they were unable to locate or access them.

The registered provider failed to assess, monitor and mitigate risks relating to the health safety and welfare of people. The registered providers policy and procedure for assessing, monitoring and improving the quality and safety of the service, was ineffective. The Quality Assurance policy for Care & Connect dated 02 February 2017 stated; "We are committed to continuous improvement and have established a quality management system which provides a framework for measuring and improving our performance; Audits (checks) of internal processes should be performed regularly." The policy stated that the registered manager is responsible for ensuring quality within the company. Despite this we found that the registered manager/provider failed to carry out audits across the service which resulted in a failure to identify and mitigate risks to the health and safety of people who used the service and others. For example, there was a failure to identify and mitigate risks associated with safeguarding people, the management of medication, accidents and incidents and the recruitment of staff.

The registered provider had a comprehensive set of policies and procedures in relation to aspects of the service and they were made available to all staff. Each policy provided statements of how the registered provider intended to conduct the particular aspect of the service and the procedures described how the policy was to be put into action. The procedures identified who will do what, what steps they needed to take and how. The documents were reviewed regularly to ensure that the information contained within them was relevant and up to date with current legislation and codes of practice. Despite this there was a failure by the registered provider to ensure that their own policies and procedures were followed to protect people from unsafe care. This included planning peoples care, acting on complaints, staff supervision and training and, reporting, analysing and acting on accidents and incidents.

Satisfaction surveys had not been completed by the registered provider and so people had not been able to formally express their views. In addition the registered provider failed to act upon complaints received. This meant that the registered provider could not act to make improvements in line with comments from people who used the service, family members or staff.

The registered provider had a service user guide in place which set out their values, principles and policies which underpinned the organisations approach to ensuring high standards of quality and safety. However during the inspection we found multiple examples which demonstrated that the registered provider failed to ensure that people received care which was safe, effective and responsive to their needs.

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

The registered provider is required by law to notify us of specific events that occur within the service. This is so that we can ensure that appropriate action has been taken in response to these. Accidents and incidents records were not available; however we identified an incident in September 2017 where a person had required hospital admission following a fall during personal care. Our records showed that we had not been notified of this event. We had also not been informed of two safeguarding concerns that had occurred within the service between April 2017 and September 2017. This meant that the registered provider was not complying with the law.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The rating following the last inspection was displayed near to the entrance of the service making it accessible for all to see.

On 20 September 2017 we requested from the registered manager/provider a remedial action plan to

provide us with reassurance that the risks identified during the inspection of 15, 18, 19, 21 and 22 September 2017 are being mitigated. We received an action plan from the registered manager/provider, within the timescale set by us. The action plan set out a specific time frame for implementing each action and who will be responsible for doing it. This included a commitment by the registered manager/provider to continue with their role as registered manager based at the office on a full time basis to ensure the effective management of the service.

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 18 Registration Regulations 2009 Notifications of other incidents The registered provider failed to notify the Commission of incidents.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider failed to ensure that service users were treated with dignity and respect.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider failed to protect service users from abuse.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider failed to ensure that staff received appropriate support, training and development.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider failed to provide service users with safe care and treatment.

The enforcement action we took:

We issued an Urgent Notice of Decision to the registered provider to impose a condition to restrict new care packages.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered provider failed to act upon complaints received.

The enforcement action we took:

We issued an Urgent Notice of Decision to the registered provider to impose a condition to restrict new care packages.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider failed to assess and monitor the quality and safety of the service and make improvements.

The enforcement action we took:

We issued an Urgent Notice of Decision to the registered provider to impose a condition to restrict new care packages.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider failed to ensure fit and proper persons employed.

The enforcement action we took:

We issued an Urgent Notice of Decision to the registered provider to impose a condition to restrict new care

packages.