Agincare UK Limited

Agincare UK Surrey

Inspection report

Unit 18
Boundary Business Centre, Boundary Way
Woking
Surrey
GU21 5DH

Tel: 02087839152
Website: www.agincare.com

Date of inspection visit:
12 January 2017
20 January 2017

Date of publication:
10 May 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 12 and 20 January 2017 and was announced.

At the last inspection in April 2014 we found breaches of Regulations 9 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the planning and delivery of care to people and respecting and involving people. We found at this inspection these Regulations continue to be breached. We also identified some new concerns.

Agincare UK Surrey is a domiciliary care agency providing personal care for people in their own homes. There were 173 people using the service at the time of the inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We have been informed since the inspection the registered manager had left the service. They are no longer registered with us.

People were not being protected against potential risks because risk assessments and guidelines for staff were not in place.

There were not sufficient staff to meet people's needs.

Medicines were not managed safely. People did not always receive the medicines they required and staff had not had their competency checked.

Staff did not always receive refresher training to help ensure they remained up to date with best practice. We have made a recommendation about staff having access to up to date training.

Staff did not receive appropriate support to enable them to carry out their duties.

People's rights were not protected because the staff did not act in accordance with the Mental Capacity Act 2005. People were not consenting to their care and not all staff had knowledge of the Mental Capacity Act 2005.

People were not treated as though they mattered or made to feel at the centre of the service as they were not always receiving person-centred care. People did not always know which care worker would be visiting them or receive the care they expected because staff did not stay for the allocated time.

Peoples care plans were not person centred and lacked the detail required for staff to help ensure they provided care that met people's needs, and care was not always planned and delivered to meet the

nutrition and hydration needs of people..

The provider did not have effective systems in place to monitor the quality of the service they provided and the registered manager did not have good management oversight of the agency.

Staff had mixed views on whether the registered manager was supportive and complained about a lack of support from head office.

People were protected against the risks of potential abuse because staff knew how to identify potential abuse and report safeguarding concerns. The provider followed safe recruitment practices and had developed plans to help ensure that people's care would not be interrupted in the event of an emergency, such as loss of utilities or severe weather.

People were supported by staff who had received induction training which included shadowing more experienced staff.

People had access to health care professionals and people and their relatives were involved in developing and reviewing their care plans. People told us their privacy and dignity was respected by staff.

People knew how to complain and the provider had a written complaints procedure. We have recommended that the way complaints are handled is improved.

During the inspection we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also made two recommendations to the registered provider. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service has therefore been placed in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not being protected from potential risks.

There were not sufficient staff to meet people's needs.

People's medicines were not always managed safely.

People were protected against the risks of potential abuse.

The provider followed safe recruitment practices.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always receive refresher training to help ensure they remained up to date with best practice.

Staff did not receive appropriate support to enable them to carry out their duties.

Care was not planned and delivered to meet the nutrition and hydration needs of people.

People's rights were not protected because the staff did not act in accordance with the Mental Capacity Act 2005.

People had access to health care professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not treated as though they mattered or made to feel at the centre of the service.

Staff were caring.

Staff respected people's privacy and dignity

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not receiving person centred care.

People did not always get the care that was planned.

People did not get the care expected because staff didn't stay for the allocated time.

People knew how to complain.

Is the service well-led?

Inadequate

The service was not well-led

There were not effective systems in place to monitor the quality of the service.

The registered manager did not always support staff.

Insufficient support was provided to the service by the provider.

Agincare UK Surrey

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.

This inspection took place on 12 and 20 January 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure the registered manager was able to support the inspection. This is the methodology we use for domiciliary care agencies. The inspection team consisted of two inspectors.

Prior to this inspection we reviewed all the information we held about the service, including information provided by the local authority. The local authority gave us permission to share the information they had about this agency. We also reviewed data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law.

As part of our inspection we spoke with seven people, four relatives, six staff, the area manager, deputy manager, the registered manager and the local authority. We reviewed a variety of documents which included the care plans for nine people, seven staff files, training records, medicines records, quality assurance monitoring records and various other documentation relevant to the management of the service.

We last inspected the service on 23 April 2014. At that inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

Our findings

People's relatives told us that they felt their family member was safe. One relative said, "I do think they are safe, It's just the way they (staff) ask if there is anything else they can do." Another said, "I do think they keep them safe when providing care."

Despite these comments however, we found people were not being protected against potential risks because risk assessments and guidelines for staff were not in place. One person used oxygen, but this had not been identified in a health and safety risk assessment. Oxygen cylinders represent a risk because they can explode and increase the risk of fire. Another person who was identified as 'anorexic' had no risk assessment or guidelines in their care plan that told staff what risks the person may face, or what action they needed to take to mitigate the risks, or intervene to seek professional help. A further person with a history of attempting suicide had no risk assessment or guidelines in place, to enable staff to identify signs or triggers and how they should respond to those. People who were at risk of falls and using mobility equipment did not have risk assessments in place and staff did not have guidelines on how to move people safely. Someone else who had a problem with their skin integrity had written in their care plan, 'on-going problem. Skin must be watched carefully'. There was no further guidance to staff to inform them on what they should do if they noticed this person's skin deteriorated. Further examples were one person who had a neurological condition increasing their risk of seizures and people at risk of malnutrition. Risk assessments were not in place for either.

The provider failed to identify and mitigate risks which is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not sufficient staff to meet people's needs. We asked relative's and staff about staffing levels. One relative said, "There are regularly problems with weekend visits. The agency do inform me when they are not able to cover a visit, which happens regularly on weekends." A staff member said, "A couple of staff leaving has had a massive impact on the rotas. Office staff are doing care calls." Other comments received from staff included, "We are short of staff", "Care plans are not in place because of staff shortages in the office", "Rotas haven't gone out because we are too short staffed. They are only done a few days in advance", "We were very short last weekend and cancelled some calls. People go sick and their cars break down. There are times when it's impossible to cover."

These concerns had been identified by the local authority who told us that numerous people had asked for them to arrange another provider because of missed calls. One person had asked them to find another provider because care staff had not turned up on a number of occasions for the tea call resulting in them ringing their son to come and make their dinner. The local authority also told us about someone being left in their chair overnight on a number of occasions because staff had not turned up. In addition, the agency had consistently told the local authority that they could not cover evenings and weekends for this person. Another person had rung their social worker to say they had spent three nights sleeping in a chair because no-one had turned up, and they could not sleep in their chair any longer.

We discussed our concerns about staffing levels with the deputy manager, registered manager and the provider's representative during our inspection. The deputy manager told us that the system they have in place does not show if calls have been missed and, "We will only know if the person calls." The provider's representative said, "On my arrival the summer was most difficult. There were problems with recruitment and retention" and, "Sickness is high in this area, we had Norovirus over Christmas." They told us that they had instructed the registered manager not to take on any more care packages in early December. However, the registered manager had continued to do so. The registered manager did not agree there was a shortage of staff but told us about high sickness levels and staff having car problems in November and December 2016. They said, "Four to five people off, it tends to be tighter." The provider's representative told us they accepted they did not have sufficient staff to meet people's needs and agreed not to accept any more referrals until they resolve their staffing levels. Following this the local authority took the decision not to refer anyone new to the agency.

The lack of a sufficient number of suitably deployed staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always receive the medicines they required. We were told by the local authority about one person whose family member had arrived to find that staff had failed to collect the person's medicines from the pharmacy. As a result they went without their medicines for five days. On checking the medicine administration records we found 16 gaps on one person's record and 22 gaps on another person's record in December. Although the registered manager completed medicines audits, none of these gaps had been identified by them. Staff had completed a workbook on medicines in the last year however only two staff had their medicines competency checked which meant the provider could not be assured that staff were confident in their responsibility in relation to good medicines management.

People's medicines were not always managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected against the risks of potential abuse because staff knew how to identify potential abuse and report safeguarding concerns. Staff told us they had received safeguarding training. One staff member said, "I'd always report to the office, always call the manager." Another said, "I would report it straight away." Training records demonstrated that all but one staff member had received safeguarding training in the last year.

Accidents and incidents were recorded appropriately. We checked the records in relation to accidents and incidents and found that six accidents/incidents had been recorded by the registered manager. We observed that appropriate action had been taken by the registered manager for all six.

The provider's representative had developed plans to help ensure that people's care would not be interrupted in the event of an emergency, such as loss of utilities or severe weather. The service had a business continuity plan, which had been reviewed in October 2016. The provider's representative said, "I have sent a 'snow plan' due to recently announced yellow weather warning for snow. This plan identifies the people most at risk if their visits do not take place in order that their care could be prioritised. Each person has been assessed regarding their level of risk and this information is used to prioritise their visits if necessary." We saw evidence to confirm this in people's care plans.

The registered manager followed safe recruitment practices. Staff files included application forms, employment histories, and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS). DBS checks identify if prospective staff have a criminal record or are

barred from working with people who use care and support services.

Requires Improvement

Is the service effective?

Our findings

People were supported by staff who had received induction training which included shadowing more experienced staff. Staff received three days induction training and completed the Care Certificate. The Care Certificate is a nationally agreed framework which sets a basic standard for the skills staff need to have in order to support people safely. A staff member said, "I had induction training. It prepared me pretty much for the role." Another said, "I think it is very good. The shadowing was very good so you could see what went on and what was needed."

However staff did not always receive refresher training to help ensure they remained up to date with best practice. It was the provider's policy to provide refresher training in safeguarding, moving and handling, infection control, health and safety, the MCA and medicines administration. This was done by staff completing workbooks. However one staff member told us, "I'm not sure if I have had refresher training. At my appraisal it may come up. I don't know whether it's my responsibility to organise it or the offices." Another said, "I have done refresher training in medication and one other. I cannot remember what." A third said, "I didn't get put on any courses." From the records we found only two staff had received dementia training, although many staff were responsible for caring for people living with dementia

We recommend the registered provider ensures that staff have access to the up to date training needed to maintain their knowledge, competence and skills.

Staff did not receive appropriate support to enable them to carry out their duties. It was the providers policy to provide staff with three supervisions (one to one meetings) a year. However in the last year we found that ten of the forty one staff had received this. Staff were unable to tell us how often supervision should take place. One said, "I'm not sure I think it should be once a year." It was also the provider's policy to provide staff with an appraisal once a year. We found from the records that only twenty four staff had received this in the last year. The registered manager had been aware of this for some time as a provider audit had identified this in February 2016 and a local authority quality visit identified this in October 2015 but action had not been taken to improve how often staff were supervised and supported. Staff told us that they did not all feel that they got the support they needed.

The lack of appropriate staff supervision and support was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care was not always planned and delivered to meet the personalised nutrition and hydration needs of people. One relative said, "I'm not sure staff always check he's eaten." The local authority told us about an incident where someone had not eaten their lunch because the food served was mouldy, and about another two people who had missed food because of staff not turning up, or not preparing food as planned. Records for one person who had an eating disorder showed fourteen occasions in one week when they had not eaten, and four days when they had not received prescribed 'Fortisip' (a high protein supplement for the management of disease related malnutrition) daily. Another person's food and fluid charts completed over a two month period showed a very poor intake, did not detail amounts and some days nothing was recorded.

None of the care plans we looked at contained nutritional assessments. Care plans did not inform staff of the food that should be provided to people or record people's likes, dislikes or dietary needs.

We discussed these concerns with the provider's representative and the registered manager. The provider's representative told us she was unaware of these issues and would arrange heightened spot checks on staff. The registered manager told us that people had expectations and some people wanted to live like that [Meaning they choose to eat mouldy food]. They said they could advise people that eating mouldy food is not safe but some people did not want to dispose of food.

Care was not always planned and delivered to meet the personalised care needs and preferences of people. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us they had food prepared by staff. One person said, "Care workers prepare meals for me, I'm happy with this" and another said, "If I need food prepared staff do it for me in the morning and wrap it up and leave it. I have never had any problems with the food."

People's rights were not protected because the staff did not act in accordance with the Mental Capacity Act 2005. 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.

There was no evidence of some people's capacity being assessed in relation to them consenting to their care, or any other specific decision. Two people had their consent to care and treatment signed by a relative without proof of the relative having Lasting Power of Attorney. The provider had completed a quality monitoring service audit in October 2016 which identified that people were not consenting to their care and that best interest decisions were not being recorded. The provider has an action plan in place to remedy this. We will monitor their progress with this at our next inspection.

There was also a risk that people's rights would not be protected because not all staff had knowledge of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We asked staff about their understanding of the MCA. One staff member said, "It's about people making decisions that are not always the right decisions and we have to make the right decisions for them." Another said, "It's a difficult area. I'm not qualified enough to decide if someone has capacity.", and a third said, "I don't know what this is. I looked at it in one course but I haven't done training on it."

As care and treatment was not always provided with the appropriate consent this is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One staff member did demonstrate an understanding of the MCA. They said, "It's about peoples independence and whether they can make decisions or not".

We spoke with the registered manager about this during the inspection who informed us they would look at alternative ways of delivering MCA training to staff to help ensure they had a good understanding.

People had access to health care professionals as staff liaised with hospitals when people were due to be discharged home and in the case of one person there was evidence staff had involved the district nursing team to support them with their needs.

Requires Improvement

Is the service caring?

Our findings

At our inspection in April 2014 we found that people were not getting their support needs met, as staff were not arriving on time. We found at this inspection this was still a concern for people as this aspect of the service had not improved.

People were not treated as though they mattered or made to feel at the centre of the service. We asked people if staff arrived when they expected them and stayed for the full length of time. One person said, "I'm happy with the service but they (staff) are sometimes late." Staff arrived for one person any time within a two and three hour window of the expected time. For another person the care workers were late seven times in a two month period. This included one occasion when staff were an hour and a half late and found the person, 'distressed as they had been trying to get out of bed for over two hours'. A staff member said, "Trouble is when someone goes off sick. Calls may be later. You have to fit them in in a gap."

The local authority informed us about one person receiving their morning calls anytime between 09:00 and 11:00 and another who did not receive their morning visit until 14:00. We heard that one person told the local authority, 'they (staff) appear rushed all of the time and they do not complete my personal care'.

A telephone survey had been completed in 2016 by the provider. Of the 32 responses received, eleven reported that care staff did not arrive on time.

We spoke to the deputy manager and the registered manager about these concerns. The deputy manager told us that the only way they would know about staff being late is if the person rang and complained. The registered manager was aware of the problem because they told us, "Some people run consistently late," and "Some staff are notoriously late. I will raise it in the staff meeting in January. We don't pay for travel time so I have to be careful how much I give because of the minimum wage."

People not receiving person-centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff were caring. One person said, "The staff are kind, caring and polite." Another said, "I'm very happy with them (the staff). They know me and I know them. I get on very well with them," and another, "I get on well with them, they are very friendly." Relative's also told us they were happy with the care provided. A relative said, "On the whole they're quite good and we're happy." Another told us, "We are very happy with them. We consider ourselves very lucky to have found them. Her regular carers are brilliant. They go the extra mile. They do lots of little things for her that we would do as a family. She's very well looked after. She gets bad tempered if she's in pain and they are very understanding of that. If they have any concerns about her well-being, they always flag them up."

Two members of staff told us how much they cared for the people they looked after. One of them an office worker said, "Office staff are doing calls. Service users are more important" and, "We try and keep the main carer for them". The other said, "I offer extra support to the family when the person dies".

People and their relatives were involved in developing and reviewing their care plans. One person said, "It's only been a short while since I've had another review. We sat down and went through it and adjusted it." A relative said, "I sat with them to do the care plan and feel it reflects all of her needs" and another, "I was consulted as they have advanced dementia." Although people felt involved in planning their care we found the care plans were not detailed enough to guide staff in delivering care to meet peoples personalised care needs. We have reported on this further in responsive.

Staff told us they would respect people's privacy. One staff member said, "I attend to personal care needs in privacy of the bedroom with door and curtains closed." Another said, "I cover the person with a towel when supporting someone with personal care".

Requires Improvement

Is the service responsive?

Our findings

At our inspection in April 2014 we found the service had not involved people as they were not providing them with a rota to show when and which member of staff would be attending to their needs. At this inspection we found this was still a concern for people and this aspect of the service had not improved. We have reported on this in the Responsive domain as it does not meet people's personalised care.

People told us they did not always know which care worker would be visiting them as they did not receive a weekly rota from the provider. One person said, "I know all the care workers who visit but I don't know which will be coming as they are supposed to send me the rota but they haven't done that for a long time so I don't know who is coming." Another said, "The agency are supposed to send me the rota but do not do this. This is not a problem in the week as the same care worker always attends, but I never know who is coming at the weekend. Once or twice they've sent people I don't know."

The deputy manager confirmed people should receive a rota each week informing them which care worker would be attending each visit but that this did not happen in practice. The deputy manager said, "Rosters are not being posted out. We try and encourage families to give an email address. I don't know why this doesn't happen." A staff member told us, "They have gone out this week. They do get emailed (if a person has an email address). Some staff don't come in to collect them and some leave them in the back of their cars." The registered manager told us during our inspection that they would now post the rotas out to people who did not have an email address.

People did not always receive the care they expected or which was funded by themselves or the local authority because staff did not always stay for the allocated time. The local authority told us about people receiving less time for visits than they expected. This included one person who had complained they were only receiving 20 minutes of a 45 minute call. They also told us there was no evidence that another person was receiving more than five minutes of their 45 minute allocated time. Records showed that most people were getting between 50% and 80% of the time for support they were meant to, and rotas showed us that because of a lack of allocated travel time some people's support was more than half being used by staff travelling to their house. One staff member told us, "Travel time is an ongoing problem." The registered manager told us. "We don't pay for travel time so we have to be careful how much (travel time) we give because of the minimum wage." They had not considered other ways of deploying staff to respond to people's needs.

Care plans were not person-centred and lacked the detail required for staff to help ensure they provided care that responded to people's needs. One person who was at risk of malnutrition had no care plan for this. They also had a diagnosed mental health condition but there was no care plan in place and no details of any professionals involved. Another person's care plan said, 'apply cream to legs'. However, the care plan did not identify what cream, why it was needed or when it should be applied. This person's care plan stated, 'Alzheimer's' as their health need but there was nothing written about what support the person needed in relation to this.

People did not always get the care that was planned. One person said, "I'm supposed to have my legs creamed every day but they don't have the time to do it." Another person was meant to have their feet soaked and creamed on a Friday. Care records did not show this ever being done by staff. The local authority told us they had visited one person who had not had their incontinence pad changed for days. This was reported to the local authority by the person's care manager. We are yet to be informed of the outcome of any investigation but we will follow this up with the local authority to find out what action was taken.

The lack of person-centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did hear from some people that they felt staff provided the care that they needed. One person said, "Overall I don't think the agency could do anything more for me. I can't think of anything to improve. Anything that I ask for I'm given. If I need my call moved because I have a hospital appointment for example, they accommodate me." Another said, "They are doing everything we require of them."

People told us they knew how to complain. One person said, "I have always been able to contact the office if I needed to." Another said, "I can always the contact office when needed. We did raise concerns about one carer and they acted incredibly quickly to put things right. I was very impressed with that."

The provider had a written complaints procedure, which detailed how complaints would be managed and listed agencies people could contact if they were not satisfied with the provider's response. We checked the complaints log and found all written complaints received an acknowledgement letter and a full response once the complaint had been investigated. However the responses to complaints that we saw were not always open or transparent, or fully investigated. One response to a complaint about a member of staff did not acknowledge that the complainant may well have had real concerns, and the complaint had not been fully investigated to determine if this was the case.

We recommend that all complaints are openly investigated and responded to with the intention of resolving the complaint to people's satisfaction.

Inadequate

Is the service well-led?

Our findings

The provider did not have effective systems in place to monitor the quality of the service they provided and the registered manager did not have good management oversight of the agency.

A member of the office staff told us that if a care worker did not arrive at a visit, office staff relied upon a telephone call from the person using the service to let them know. This member of staff acknowledged that this did not always happen, and that visits had been missed because neither the care worker nor the person had contacted the office. We asked for information regarding the number of missed calls in the past month. Staff in the office and the registered manager were unable to supply this information as they told us there were no systems in place to record these.

The registered manager carried out a telephone survey in February 2016. The telephone survey identified that people were not receiving information on who was going to be providing them with support and when, and that staff were not arriving on time. This information had not led to any action being taken to improve this aspect of the service.

Quality monitoring service audits in February and October 2016 were carried out by the provider. The audit assessed the management of areas including care and support, safeguarding, complaints, recruitment, training and the support provided to staff. Both audits identified that some staff had not received supervision and appraisal in line with the provider's policies and procedures. The audit in October 2016 identified that peoples care plans were 'not person-centred and had not met the best interests of the people receiving the service'. Following this audit an action plan was developed by the provider's representative. The audits had not led to improvements, and neither the registered manager, nor the provider had addressed these shortfalls by the time of this inspection.

We were told by the local authority they had visited people's homes and had found mouldy food on worktops and fridges and people's premises left in an untidy and unclean way. This demonstrated that regular field spot checks were not carried out to help ensure people received good quality care. Nor had staff been reporting these concerns to the person's family or the local authority. In the last year 16 out of 41 staff had received a spot-check. One staff member said, "Spot checks are not that often but sometimes they do them," and another told us, "It happens more often with day time staff." Those spot checks that had been completed had identified competency issues with moving and handling and medication, but there was no evidence of intervention, training or re-assessment.

Although medicines audits were carried out by the registered manager, these were not completed in line with their audit guidelines and did not identify shortfalls in medicines processes. We saw the results of audits from November and December 2016 and the registered manager recorded 100% compliance, however they had audited 10 of the medicines charts, rather than 51 which would have been in line with their policy. We found significant gaps in staff recording that medicines had been given and that people had been without their medicines for days due to staff failing to manage stock or report low stock. These shortfalls had not been identified through the providers own monitoring systems.

The local authority informed us and supplied evidence that they had spoken with the agency on numerous occasions to highlight the failures to deliver safe and effective care to people. The registered manager and provider did not take these opportunities to learn and make improvements to the care in the service.

The records were not always accurate or up to date. Care plans were not always completed to allow staff to see what care they needed to give people. Risk assessments were either not completed or not detailed enough for staff to be guided in recognising and minimising risks to people. Medicines charts were not always completed to show medicines had been given.

The lack of effective quality assurance processes leading to improvements and the lack of accurate, contemporaneous records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had mixed views on whether the registered manager and provider were supportive. One staff member said, "I feel supported but feel there are more negatives than positives fed back to staff. It was a few staff who weren't doing things correctly, but the directive was sent out to all." Another said, "The manager is not supportive. All staff are unfriendly and don't help me – more care staff, rather than office. I have never had that experience before. We don't work as a team at all." A third told us, "The manager is totally supportive. I can rely on them. They will help me in any way they can. I feel valued. They are always grateful for the job that I do and tell me the clients are happy with me," and another said, I never feel alone when I have the on-call phone. I know I have back-up. I can ring (person's name) at 06:00 in the morning." Staff did not always have the opportunity to discuss these issues or suggest ideas for improvements because staff supervision was not carried out regularly.

Some staff complained that insufficient support was available from head office. One staff member said, "I don't feel we get support from higher management. We have had a difficult year with staffing. At points we have not had coordinators or admin staff. It's been very difficult. The manager has had to do rotas as well. Head office promised help but it didn't materialise. It was a long time. I don't think the support is enough. I feel let down by them." Another said, "We have had a few new staff in the office. They have found it stressful. They don't last. Head office doesn't support us. They are not helping get new staff."

A new area manager had been in post for five months and had been making efforts to work with the registered manager to identify the failings and take action. They had developed a robust action plan in October 2016 and this was starting to be worked on. Although the changes had not led to significant improvements in peoples care or the management of the service at the time of this inspection.

Shortly after the inspection we were informed that the registered manager had resigned. The provider's representative told us they had a plan in place to recruit a new manager who they say they will support to make the necessary improvements.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that people's care was planned and delivered to meet the personalised care needs and preferences of people. The provider had not ensured that people were receiving person centred care.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that people's care and treatment was provided with appropriate consent.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that risks to people were identified and mitigated. The provider had not ensured that medicines were managed safely.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that sufficient numbers of staff were deployed.

The provider had not ensured that staff received appropriate supervision and support.

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 17 HSCA RA Regulations 2014 Good governance The provider did not have effective quality assurance processes. The provider had not ensured that people's records were accurate and contemporaneous.

The enforcement action we took:

Warning notice issued.