Foxenden Healthcare Ltd

Kare Plus Guilford

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Care service description

Kare Plus Guildford is a domiciliary care agency. It provides personal care to people living in their own homes in the community. It provides a service to older and younger people some of whom may be living with dementia or have a learning or physical disability. At the time of our inspection the service provided a regulated activity to 36 people.

Rating at last inspection

At our last inspection we rated the service Good. This latest inspection was partly prompted by an incident which had a serious impact on a person using the service and this indicated potential concerns about the management of risk in the service. While we did not look at the circumstances of the specific incident, which may be subject to criminal investigation, we did look at associated risks. The Local Authority also made us aware of ongoing concerns that related to staff not attending calls to people using the service.

The registered manager was not available on the day of the inspection. 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. Instead we were supported by the provider.

People's medicines were not being managed in a safe way which put people at risk. Staff were not trained or assessed as safe to administer medicines to people. Accidents and incidents were not always reported and actions were not always taken to reduce reoccurrence of them. Good infection control was not always being followed by staff and assessments of the risks associated with people were not always assessed. Where people were at risk of malnutrition or dehydration there were sufficient processes in place to monitor this.

The provider had not ensured that there was sufficient organisation of the staff rotas and we found that staff were at times late for calls of failed to attend calls. The provider, registered manager and staff were not following procedures that related to safeguarding people from the risk of abuse or neglect. The recruitment of staff was not robust which put people at risk.

Staff were not sufficiently trained or supervised to ensure that they were competent to carry out their role. There was a lack of understand of the Mental Capacity Act and its principles. Where people's capacity was in doubt there was no assessments undertaken by the registered manager. Prior to people receiving care there was a lack of assessments of their needs. Where advice was needed to be obtained to support people, health care professionals were not always being contacted. Appropriate systems were not in place to ensure that staff were communicating changes in people's needs.

People's care was not provided in a consistent way. People were not always sure who would be attending their call and told us that this caused them anxiety. People were not always involved in their care planning. Where they asked for staff to attend the call at a particular time this was often not adhered to. Care plans lacked information about people's backgrounds, interests and things that were important to them. Where people were being cared for at the end of their lives there was no care planning in place around this.

Care plans lacked detailed and guidance for staff. There were times where staff were delivering care without having any information about the person's needs. Where there was a change to people's care their care plans were not updated to reflect this. Where people and relatives complained about their care, this was not recorded and insufficient actions were taking place to address their complaints.

People, relatives and staff felt the service was poorly managed. Appropriate steps had not been taken to ensure that staff were attending calls or whether they were staying for the full length of the call. There were no systems in place to assess the quality of the care being provided. The provider was not following their own processes in relation to the care provision. Staff told us that they did not feel valued or supported.

Notifications that are required to be sent to the CQC were not always being done. This included incidents of safeguarding.

There were people and relatives that told us that they felt safe with staff at the service and felt that staff were aware of the risks associated with their care. Relatives did say that there were staff that were aware of their family members health needs and contacted them if they were concerned.

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 the more serious 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.

Medicines were not being managed in a safe way and there was not always guidance for staff in relation to medicines. Staff were not following good infection control.

Risks to people's care was not being reviewed, updated or monitored in a safe way.

Recruitment of staff was not robust which people at risk. People were not protected against the risk of abuse and improper treatment. Staff were not aware of their roles and responsibilities in how to protect people.

Is the service effective?

Inadequate

The service was not effective.

Assessments of people's needs were not undertaken appropriately.

Staff were not provided with training and supervised in relation to the role. People's health care needs were not always being monitored effectively.

People's human rights were at risk because the provider had not followed the requirements of the Mental Capacity Act 2005 and people's capacity assessments were not always completed appropriately.

Staff were not communicating changes to people's health.

Is the service caring?

Inadequate

The service was not caring.

People were not supported by a consistent team of staff. At times people were not receiving their call and often staff were late attending the call.

People's preferences, likes and dislikes were not always taken into consideration and support was not always provided in accordance with people's wishes.

People and relatives fed back that staff were kind and respectful towards them.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were not always in place. Where they were they were not always detailed and lacked guidance for staff. Care plans were not updated when a person's needs changed.

There was insufficient planning around people's end of life care.

Complaints were not recorded or responded to.

Is the service well-led?

Inadequate

The service was not well-led.

People, relatives and staff felt that the service was not well led. Staff did not always feel supported or valued.

Appropriate systems were not in place to monitor the safety and quality of the service. Staff were not following policies that related to the care provision.

The provider had not sought, encouraged and supported people's involvement in the improvement of the service to improve the quality of care.

Appropriate notifications were not sent to the CQC when required.

Kare Plus Guilford

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was partly prompted by an incident which had a serious impact on a person using the service and this indicated potential concerns about the management of risk in the service. While we did not look at the circumstances of the specific incident, which may be subject to criminal investigation, we did look at associated risks.

This inspection site visit took place on 18 January 2019 and was unannounced. The inspection team consisted of three inspectors. At the office we spoke with the provider and four members of staff. We read care plans for five people, reviewed medicines records and the records of accidents and incidents. After the inspection the provider sent us the contact details for people using the service and policies that related to the running of the service.

Before the inspection we reviewed records held by CQC which included notifications. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. We also spoke with a relative of a person using the service.

Due to the inspection taking place sooner than we expected we did not ask the provider to complete a PIR. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.
After the inspection we spoke with three people and six relatives of people that received care.

Inadequate

Is the service safe?

Our findings

There was a risk that people that were not receiving their medicines when required. The medicine administration records (MAR) were pre-printed at the office. Information on the MAR did not indicate what form the medicine came in, for example, in tablet form or liquid. The information also did not state whether one or two tablets were required to meet the prescription requirements. This was despite the service policy stating, "The documentation for the medication should clearly reflect the Service User's name, the name of the prescribed medication, date, time, dose, route and frequency of administration."

Staff were unable to provide us with evidence of how they knew what the person's medicine was. They told us that they took the information from the GP surgery however they told us that there were no records of this. The MAR charts were not always accurately recorded. For example, one person's MAR had their name on the front sheet however another person's name appeared on the administration sign sheet. We found that staff were recording that all medicines had been given rather than signing what each of the medicines given were. According to one person's MAR one medicine had to be given once a week. As staff were not indicating what medicines they were giving there was a risk they were having this medicine more than once a week.

Recording of reasons why medicines were not given were also inconsistent and unclear. For example, there were gaps on the MAR charts with no additional information on whether the person had been offered and refused or whether the medicine had been missed. Where a person had a medicine patch staff were inconsistent with recording where the patch had last been placed on the person's body. Where people required 'as and when' medicine there was no guidance for staff on when this needed to be offered to the person. One member of staff told us, "The medicine charts are a joke. They don't make any sense. They are so hard to read."

There was no evidence that staff had been competency assessed to ensure that they had the skills required to administer medicines. One relative told us, "Mum would say she had taken her medication and they would take her word for it rather than checking." One member of staff said, "I have never had a competency check [in relation to medicines]. I should have them as I want to know what I am doing wrong." The provider told us that they thought that staff completing shadowing visits with experienced staff members to look at medicines administration was sufficient but now understood this was not an acceptable induction. The service policy stated, "Only staff who have undertaken Kare Plus Guildford Medication Training Course and who have been assessed as competent should be involved in the administration of medication." We found that this was not happening and only one member of staff had received formal medicine training.

Accidents and incidents were not always reported or recorded which placed people at risk. There were insufficient process in place for staff to report an accident or an incident in a person's home. Where calls were made by staff to the office with a concern about a person these were not always recorded or followed up by the registered manager. One member of staff told us each month they would collect daily care notes from people's homes. They would then write important information from these notes on to the electronic care records for people retrospectively. We saw that staff were recording when people had been unwell,

where people or their families had been unhappy with the care call or information about people's changing needs. There was no records of any follow ups to these concerns written in the care notes. For example, on the electronic care notes for one person it was recorded that one person had, "On arrival [person] had fallen out of bed, said his right shoulder hurt and also his right leg." Although there was a record that a paramedic was called no incident form was completed by the member of staff and no information on what actions were taken to prevent reoccurrence. Staff were not following the service policy that stated, "After the accident/incident investigation and all matters concerned with it are complete, a copy of the signed accident/incident form should be placed in the personnel file of any person(s) affected by the accident, and the original placed in the accident book."

Staff were not always following good infection control which put people at risk. People we spoke with told us that staff did not always wear gloves and they never saw staff wear aprons. One relative said, "They [staff] never changed their gloves in between providing personal to my [family member]. Staff never ever wore an apron which concerned me when they had to go to the next client. It breaks my heart." The service policy was not being followed in relation to this. It stated, "Care Staff should avoid soiled linen touching their skin or clothes." Another told us that staff would often say that there were not enough gloves available for staff. One person said, "They usually wear gloves but they never wash their hands before they leave." Staff were not following the service policy that stated, "The use of gloves does not replace the need for hand hygiene. Gloved hands should not be washed or cleaned with alcohol handrub. Hands should be washed after the removal of gloves."

Risks to people were not appropriately assessed and measures were not always in place to ensure that people were cared for appropriately. A relative told us that a sore had developed on the their family member's sacrum. They told us, "Staff did not adhere to the proper care." They told us that they had to show the staff how to properly care for their family member to reduce the amount of discomfort to them. They said, "They [staff] were too rough with him." One member of staff said, "We have had no training in relation to caring for pressure sores." Another relative told us that their family member required two care staff to mobilise them. They said often a member of staff would move the person without the support of two staff which put the person at risk. A member of staff said that one care staff was often sent to another person to mobilise them when two staff should have been present.

People's care plans did not always have sufficient information for staff to reduce the risks associated with their care. One person's care plan was ticked 'yes' to there being risks from the use of mobility aids and of injury from slips or falls. However, the care plan stated that no moving and handling risk assessment was required. A relative told us that their family member's mobility had deteriorated and they now required two care staff. However, their care plan had not been updated to reflect this. The care plan stated under assessment of identified risks that they were 'low risk' in terms of their mobility. The person was at risk of skin breakdown but there was no information in their care plan around this.

People's nutritional and hydration risks were not always managed safely. One person had been identified as nutritionally at risk and required to have food and fluid charts. There were notes on the charts stating that, "Must be filled in at every visit. Must report to the GP or DN if [person] is not eating and drinking." The charts were not always being completed by staff and there was no target information for how much fluid the person needed. Staff were recording on the person's daily care notes that on several occasions the person was reluctant to eat or refused their meal. This had not been reported to the office by staff.

As medicines, infection control and risks were not always being managed in a safe way this is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected as staff were not following safeguarding procedures. Where staff had identified a person had a missed call they were not reporting this to the office appropriately. For example, we identified that one person was left in their arm chair overnight. This was not brought to the attention of the local authority until a relative had raised the concern with them. According to the office notes another member of staff identified unexplained bruising on a person's arm and another occasion an unexplained cut on their arm. Neither of these incidents were reported to the office as a safeguarding concern or referred to the Local Authority as a safeguarding concern. One member of staff when asked about the safeguarding policy stated, "I don't know if some of them [staff] would recognise what safeguarding was." The provider, registered manager and staff were not following their own safeguarding policy that stated that they should, "To be able to recognise and report incidences of harm, to report concerns of harm or poor practice that may lead to harm, to remain up to date with training and to follow the policy and procedures." Staff had not completed safeguarding training.

As people were not always being safeguarding against the risk of abuse or neglect this is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not deployed effectively to ensure that people received the appropriate care. There was lack of organisation by the registered manager to ensure that where two staff were required at a call this had been organised. People and relatives fed back that when two care staff were required the second member of staff often failed to attend or was late. Relatives also fed back that calls at times were not attended by any staff. One relative said, "The first night I was expecting them they did not turn up at all. I tried calling the staff member and they did not answer the call. They called me back saying they had fallen asleep." The relative told us, "It was causing more upset. I just didn't know where I was." Another told us, "I'd try and call constantly when double-ups weren't turning up but you wouldn't get an answer." A third told us that staff did not attend a call one evening and that their family member had to sleep in their chair.

The provider told us that rotas were sent electronically to staff. They said that any changes to the rotas would be done electronically. However, unless staff, "Refreshed" the data on their smart phones staff would not always know that there may have been a change to the rota. Despite the provider identifying this problem no actions had been taken to address this. We also found that where two care staff were required to attend a call this had not always been organised on the rota. One member of staff said, "There are not enough staff and the impact is that [the registered manager] will have to do the calls." They told us that often staff would ring on the day to say that they cannot do the call. They said, "I have flagged this [with the provider] for months." Another told us, "I just can't believe that people [staff] don't turn up to people." They told us that they were frequently asked to cover calls where staff had called in to say they were unable to work a particular shift. A third told us, "We have enough [staff], when these staff chose to work is the issue if they actually turn up. They ring in and say they are not working that day."

As staff were not deployed in a way to ensure that all calls were attended to this is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk as the provider had not ensured that all new staff were thoroughly checked to ensure they were suitable to work for the service. The providers policy stated that they required two references for staff before they started work. Two of the staff files only had one reference. One was from the staff members friend and the other one did not relate to the person's most previous work at a care establishment. There were gaps in staff's employment that had not been explored by the provider.

All staff had undertaken enhanced criminal records checks before commencing work the provider had ensured that staff had the right to work in the country. There was also evidence of staff members identity.

As robust recruitment procedures were not in place this is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were people and relatives that felt that staff did manage the risks to the care. One relative told us, "They've always turned up and stay. If Mum's not been in they've made checks so they know she hasn't fallen in the house." Another told us, "[Member of staff] and the people [staff] who come now are lovely and know how to help Mum so I feel she's safe. Mum likes having them." A third said, "We feel secure and safe with them [staff]."

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 a person lacks the mental capacity to make a particular decision, any made on their behalf must be in their best interests and the least restrictive option available. Where people's capacity was in doubt there was no evidence that MCA capacity assessments or best interest decisions had taken place in relation to consent to care. For example, one care plan stated, "Result is person requires a referral for capacity assessment." There was no assessment in place. At the last inspection in 2017 the registered manager told us that they were implementing MCA capacity assessments where necessary. We found that this had not taken place.

One member of staff was unable to say whether they had received MCA training and lacked understanding of its principles. They told us," The purpose of MCA is to keep people safe and that they know their rights." The providers policy stated, "All staff of Kare Plus Guildford are given training in the Mental Capacity Act." Based on the training matrix that the provider sent to us none of the staff had received this training.

As the requirement of MCA and consent to care and treatment was not followed this is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported by staff that had undergone a thorough induction programme to give them the skills to care for people effectively. We identified through discussions with relatives and staff that staff were not given appropriate training on how to move and handle people in a safe way. One member of staff told us, "People are at risk because staff don't know how to use the hoist. There are enough staff but they need proper training." We checked the training matrix and found that no staff had received face to face training that related to using moving and handling equipment. Whilst the provider had now booked this training for staff they were still delivering care to people which put them at risk. The service policy stated, "All new members of staff, will successfully complete an induction programme to the standard of the Care Certificate, within 12 weeks of appointment." We found that this was not taking place.

We saw from the training matrix that out of 26 staff delivering care 10 had not had an induction. Where training was provided this was not effective in ensuring that staff were providing good care. We found poor practice around infection control and safeguarding during our inspection. One member of staff said, "A lot of the most recent carers need more training. They do the e-learning and some shadowing but they want to learn more. Even when they [staff] would ask for more training it wasn't given." Another member of staff said, "We haven't had appropriate training and I never shadowed anyone when I started." They said, "The biggest risk here is training." Staff were not completing the care certificate or the equivalent of. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.

Care staff had not always received appropriate support that promoted their professional development and assessed their competencies. Before staff delivered care to people for the first time there was no system in

place to ensure they were assessed as competent to fulfil their role. There were no spot checks undertaken to review the care being delivered and staff were not attending one to one supervisions with their manager. One member of staff said, "I have never had a one to one supervision. We should have them to check our competence."

As there is lack of staff training, knowledge and competency this is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to people using the service, we found that there was a lack of detailed assessments taking place to ensure that the service was able to meet people's needs. We asked to look at the pre-assessments and were told by a member of staff that once they had transferred information onto a care plan they had been told to shred the assessments. We did see some assessments of needs by the registered manager that had been hand written over the local authorities care assessments. These were difficult to read and lacked any meaningful information about the needs of people and how they wanted their care to be delivered.

We saw examples of where the needs of people had not been appropriately assessed. For example, one assessment stated that the person would not eat or drink without prompting, and assistance eating. The plan also stated that the person could become, "Distressed" with personal care which was also required at each visit. The registered manager had agreed this package of care for staff to provide this care within 30-minute calls which based on the person's needs was not sufficient time. No action had been taken to go back to the local authority to review the visit times. The provider agreed that this was insufficient time for staff to meet the person's needs.

There was a risk that people were not being supported with their health care needs. Although the electronic notes in the office contained some information about the GP or community nurses being contacted by staff, there was a lack of recording of what actions had been taken when people were unwell. We saw electronic notes written retrospectively where staff had indicated that a person was unwell but there was very little recording of whether health care professionals had been contacted to support the person. For example, one set of notes written between the 16 October 2018 and 12 December 2018 stated that the person was refusing care and appeared unwell. There were no records of what actions had been taken to address this. Another person's health had deteriorated significantly. Staff advised us that they had contacted health care professionals in relation to this however they confirmed that no records were made. This is subject to a safeguarding investigation.

There was no joined up approach to care by the staff that were working at the service. Staff were not always completing the daily care notes to confirm what care had been given. This is particularly important if staff attending the call needed to be aware of any concerns from the previous visit. One member of staff said, "I feel like the basics haven't been completed. Things like daily logs. We're all human and forget sometimes but some staff would never do them."

As an appropriate assessment of people's needs was not taking place, staff were not always sharing concerns about people's care and appropriate health care professionals were not consulted in relation to people's care this is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were people and relatives that fed back that staff were aware of their family members health needs. One relative said, "They're [staff] very good at spotting when somethings wrong. We had a call last week to say they thought Mum had an infection and could we ring the GP."

Inadequate

Is the service caring?

Our findings

People did not benefit from continuity of care from staff who knew them and understood their needs. People and relatives fed back that they did not always know which member of staff was attending their call. They told us that often they would get a member of staff that had not attended the call before. One relative told us, "We don't get the same carer on a regular basis. It would make life a lot better for [family members name] if they knew her." They told us that when new staff arrived, "They will just stand there and need to be prompted." Another relative told us, "I requested the rota over and over again and I was never given one." A third told us, "I've raised a few issues. When the usual girls [staff] are there it's okay but when it's someone different they don't always go through everything." A fourth said, "People [staff] would turn up at the door and not even know where Mum was in the house. I didn't like it when people came who'd never been before and didn't know how to do things."

Individual care staff were well meaning and kind towards people. However, the service that was provided to people meant that at times they were not always treated in a caring and dignified way. Examples of this include one person that was not supported to bed one evening and was left in their chair overnight due to the call being missed. People were at times left anxious due to staff being late or staff not turning up without any contact from the office to provide reassurance or support. One person told us, "I've had a few problems with them where they haven't turned up on time. I like to go to church on a Sunday but I've missed a few times recently because they haven't arrived on time to take me."

People choices around their care delivery was not always considered. People and relatives told us that although it was agreed with the registered manager the timing of the call often this was not adhered to. One person said, "I go to Church. Sometimes I am still waiting for them to arrive to get me ready to go out." One relative said, "If the care staff are very late this impacts on the rest of the day. A lot of the time [when staff are very late] we will just send them away. It's annoying." Relatives told us that they were never contacted to confirm that were running late. One relative told us, "They [staff] never contacted me to say they were going to be late." Another relative said, "[Family member] gets upset as she needs that routine."

People were not involved in their care planning. There was no evidence in people's care plans that people and relatives (where appropriate) were involved in the planning of their care. Care plans contained little information around how people communicated, their spiritual needs, their likes and dislikes and whether they had a preference of a male or female carer.

As people did not always have choices around their care delivery and were not always treated in a caring way this is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite this people and relatives fed back that they had good relationships with some of the carer staff that visited them. One person said, "The carers are all very nice, very good, I do like them." Another told us, "They [staff] ask me before they do anything, they are quite a friendly lot." One relative told us, "Some of the staff are good, helpful and kind." Another told us, "Staff were respectful and dignified towards my [family

member]."

There were examples of where staff provided care and support to people and their relatives. One relative told us, "They [staff] really care for us both, they are here to care for my [family member], but when I was unwell over Christmas, they also helped me by getting me in some food as I was unable to go out. Can't rate them highly enough." Other comments included, "They [staff] all know mum and how to handle her. It helps me a lot and takes the stress away from me. I love the girls." Referring to one member of staff they said, "She is absolutely amazing." and, "They're very friendly and reliable. She [the member of staff] speaks to Mum nicely, doesn't treat her as though she's a job. She treats her like a family member and I can tell Mum feels really comfortable with her."

Inadequate

Is the service responsive?

Our findings

People were cared for by staff that did not have information about their care needs. We found that care plans had not always been developed before staff provided care. One member of staff told us that it was four months before a care plan was developed for one person. Another member of staff said, "There isn't always a care plan. We never know people's needs before we go in. You are not told what to expect. It's horrible not knowing what to expect. You need to know these things." Another told us, "Care plans aren't fit for purpose. We should be able to access them through our phones when we start with someone new but it can take weeks to get a care plan."

Care plans were not personalised and did not always have detailed guidance for staff specific to each person needs. For example, one care plan stated that the person had behaviours that were challenging. However, there was no guidance for staff on how best to support the person with this. A member of staff told us that the care plan for this person did not reflect them or their needs. We checked the initial assessment from the Local Authority who were commissioning the person's care and there was no reference to the person having behaviour that challenged. Another person's care plan stated that they required assistance with eating and drinking and that they became distressed during personal care. There was no additional information for staff on how best to approach personal care. A member of staff told us, "The care plans are atrocious."

People's care was compromised as care plans were not updated or revised when they had a changing need. One relative told us that their family members mobility had reduced. They said, "The care plan was never read by the staff and it was never updated when his needs changed." They said, "It was the most abominable care I have ever experienced in my life." We checked the person's care plan and identified that although the person's was being cared for in bed and required particular skin care this was not included in their care plan. We asked a member of staff what they would do if they identified a change in a person's needs. They said, "Report to office and review care plan." However, there was no evidence that staff were doing this consistently.

People were not always supported with their end of life care planning. We were aware that there were people using the service that were near the end of their life. There was no information in their care plans on discussions with them and their relatives on their wants and wishes.

Care and treatment was not always provided that met people's individual and most current needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's complaints were not recorded, investigated or responded to that ensured improvements in the care delivery. There were mixed responses from people and relatives about whether they felt confident in making a complaint. One relative said, "I've never complained but think they'd deal with it there and then if there was anything." Another told us, "When they'd missed the call and I rang them and they sent someone out straight away to help me get [their family member] in the shower." Whilst others told us that they were not confident that complaints would be investigated. One relative said, "I complained about the missed

calls. Not once did they investigate the complaint. Out of common courtesy you would have thought I would have had an apology and I never did." Another told us, "I have made complaints but it's like you are standing there banging your head against a brick wall." The service policy stated, "A full record will be held of all complaints received regardless of the level of seriousness and means of communication." We checked the complaints folder and found that people's and relatives complaints were not recorded and there were no records of how many complaints had been received.

As actions were not taken as a result of complaints this is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

People and relatives told us that they were not satisfied with how the service was being managed. One relative said, "It's very badly managed. It needs a good organiser." Another said, "No one knows what's going on there [at Kareplus]." A third told us, "They are all very nice but they lack organisation. I need to be on top of them all the time. One of the things they agreed after last October was that they would always respond to emails but I hardly ever get a response first time. It took four emails before they replied."

The provider had not taken appropriate steps prior to the inspection to ensure that peoples' care was adequate. When we arrived at the inspection we explained to the provider that we were there due to concerns that had been raised by the Local Authority that related to missed calls and poor quality of care. They were already aware of these concerns and told us, "I've dug and found more issues. I have assumed everything is under control only to find it hasn't been. I know this is my fault." They told us that they had not been undertaking any audits of the service and had relied upon the registered manager for this. The service policy stated, "The Nominated Person or delegated other will undertake monthly quality control audits and reviews of their service as dictated by the quality framework." This was not taking place.

Systems in place to monitor the delivery of care were not robust and this impacted on the care that people received. In July 2018 the provider was made aware of missed calls to people that received care. They assured us at that time that they were introducing a new electronic logging in system so that they would know that staff had attended a call and stayed for the duration. On this inspection the provider told us that this logging system was not in place and never had been. No other systems had been put in place to ensure that they knew that staff had attended calls. We were made aware by the Local Authority and relatives of people that there had been several missed calls. We asked the provider if they were able to tell us how many missed calls there had been but they were unable to tell us this. They told us that they could not be sure if staff had attended calls as staff were not always completing the person daily notes.

Quality assurance checks were not always robust in ensuring that the care to people was safe, effective and responsive to their needs. We saw that 'Quality Service Review Forms' had been completed for three people. Each of these identified areas for improvements but there was no information on what actions had been taken to address these. For example, one person asked if staff could wear badges so they knew who they were. Another person had asked that more regular carers attended and fed back that the office was, "Not performing as expected" and, "Lack of communication." The person marked the service as, "Poor" with regards to how well they were meeting their needs. The third person fed back that, "Care is different depending on who comes, carers rarely stay the length of visit. Would like consistent carers." We found during our inspection that these shortfalls were still taking place.

The service was not following their own policy that related to reviewing the quality of care. The policy stated, "Kare Plus Guildford will ensure that there is effective governance, including assurance and auditing systems and processes. These will assess, monitor and drive improvement in the quality and safety of the services provided, including the quality of the experience for Service Users. The systems and processes will also assess, monitor and mitigate any risks relating the health, safety and welfare of Service Users and others.

Kare Plus Guildford is committed to ensuring that we continually evaluate and seek to improve our governance and auditing practice."

Staff felt unsupported and devalued which directly impacted on the care delivery. One staff member said, "I feel supported from [the provider], but not from the care manager. I feel she doesn't listen." Another told us, "I felt she [the registered manager] wasn't dealing with concerns. She wasn't answering the on-call phone when I needed her help." A third said, "I don't feel supported or valued. My workload keeps going up." A fourth said, "I have no confidence [in the leadership] and we have been saying this for a long time. You know when you are out there [on calls] no one is going to save you if you are in trouble. I feel vulnerable." We asked to see the minutes of staff meetings however they could not be located. We were only provided with the agenda for an "Annual Team Meeting" in March 2018. To date we have not been provided with any evidence of any other staff meetings that had taken place.

People were not always receiving their full call as staff were not given travel times between calls. One member of staff said, "We get no travel time. We were recording the exact time we were at the call but [registered manager] told us to write the times we should have been there as it didn't look good." They told us that if they were at a call for 45 minutes they would still record that they had been there for an hour. We reviewed the time sheets for staff and saw that these were being recorded with incorrect information. We saw several examples of where staff were recording that they had left a person's home and arrived at another call at the same time. This meant that the time sheets were not always accurately reflecting the length of time staff were staying at a call. This had not been picked up by the provider. One relative said, "Staff were writing times [that they arrived] that were false."

As there was a lack of leadership and systems and processes were not established and operated effectively this is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the inspection the provider sent us an action plan to provide assurances on the immediate risks to people's care. They assured us that staff would contact the office when they arrived at each call. People and relatives we spoke with told us that this was taking place. One relative said, "I'm a bit suspicious still so keep a very close eye on things. They rang last week to check the carers had been so they've obviously put some sort of checking processes in place." They were also reviewing the staff rotas to ensure that where needed two staff attended calls. They told us that they were reviewing the medicine administration for people and updating people's care plans. We will check this on the next inspection.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. Prior to this inspection we were notified by the Local Authority safeguarding incidents that occurred at the service. These at the time had not been notified to us by the registered manager. The registered manager told us that they did not know that this needed to be done. However, the service policy states that, "By law, Kare Plus Guildford must notify the Care Quality Commission without delay, incidents of abuse and allegations of abuse." Whilst on the inspection we identified several incidents of safeguarding that had not been notified to the CQC.

As notifications were not always been sent in to the CQC this is a breach of regulation 18 of the (Registration) Regulations 2009.

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to ensure that appropriate notifications were sent to the CQC

The enforcement action we took:

We have issued a fixed penalty notice