Direct Health (UK) Limited

Direct Health

Inspection report

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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

Overall summary

This inspection took place on 14 January 2015 and was announced. This meant we informed the provider at short notice of our visit. When we last inspected the service in January 2014 the provider was meeting all the required standards.

Direct Health provides care to people in their own homes. There were 1000 people who used the service at the time of our visit.

There was a registered manager in post at the time of our visit. A manager is required to register with us by law. 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 (Regulated Activity) Regulations 2014 about how the service is run.

The service was not providing consistently safe care.

Not all risks were identified and managed. People's care plans did not always reflect their care needs and risk assessments were not always in place.

Summary of findings

Staffing levels appeared good, but there were a high proportion of missed late and irregular calls which meant people's safety was compromised.

Where the service was responsible for people's medicines, people were at risk, as they did not always receive their medicines in a timely manner.

Most people told us they were well cared for, but some people and their relatives expressed concerns about staff skills and knowledge. Inductions had taken place, but staff supervision was not up to date. There were gaps in staffs on-going training. People's on-going health needs were not always met.

People's nutritional needs were met, but some people had varied experiences, when the service was responsible for supporting people.

Some people were happy with the care provided by the service. They told us the staff were kind and respectful at all times. Staff we spoke with told us they had clear values to ensure people were treated with dignity and respect.

Some people were able to express their views by completing a service questionnaire about how the service was run, but this did not reflect all the views of people who use the service. Some felt their views were not always taken on board.

People did not have access to an advocacy service, or appropriate information to support them make informed choices

Systems in place to monitor and improve the quality of the service provided were not robust enough to highlight concerns.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which, corresponds to the Health and Social care Act (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report. People did not receive planned care and support that was relevant to their needs and delivered in a safe way. People's needs were not always identified, assessed and managed according to risk. Complaints were not always investigated or resolved to the satisfaction of the person who used the service, or people acting on their behalf.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Inadequate

People received inappropriate call times that made some people feel unsafe. Some people were left unsupported and without care.

Staff were aware of what constituted abuse and followed the service processes when reporting concern about safeguarding adults

Staffing levels appeared good, but due to some issues raised people's safety became compromised.

Medicines were not always managed safely and people did not consistently receive them on time.

Is the service effective?

The service was not consistently effective.

Requires improvement

People did not always receive effective care relevant to their needs.

Staff sought appropriate consent before providing care, but people who lacked capacity to make decisions had not always been assessed.

People were supported to eat and drink, but the service did not always identify risks to people receiving out of date food.

People did not always experience positive outcomes regarding their health needs.

Is the service caring?

The service was not consistently caring.

Requires improvement

People were not always treated in a kind and respectful manner by staff and felt their care was rushed at times.

People felt they were not always listened to or received sufficient information about the service.

Most people felt their privacy and dignity was respected by caring compassionate staff. Staff were able to describe how they supported people's dignity and promoted independence.

Is the service responsive?

The service was not consistently responsive

Requires improvement

People were not confident staff would respond to their needs in a timely manner.

Summary of findings

People felt they were not always at the centre of the care they received as sometimes staff focused on the tasks they were doing rather than them as an individual.

People were aware of how they should raise a complaint or concern, but felt the service did not always take their views fully on board or change the practice to improve the service.

Is the service well-led?

Inadequate

The service was not consistently well-led.

People did not always receive enough up-to-date information on how the service was run.

The service sought people's views, but did not always respond back to them in a timely manner.

The leadership was reactive and the way the service was managed did not always identify all the risks to peoples care needs.

There were no plans in place to ensure the service ran smoothly.

The monitoring systems in place were not robust or consistent to ensure the service was effectively run and people received the care that reflected their needs.

Direct Health

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 14 January 2015 and was an announced inspection. This means we informed the service at short notice that the inspection would take place.

The inspection team consisted of two inspectors and an expert by experience who contacted people who used the service by telephone. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with 17 people and four relatives of people who used the service. We spoke with 10 care workers, two care coordinators, two senior members of staff, the registered manager and the regional manager. We looked at some information in documents, which included 12 care files, six staff files and relevant management files.

Inadequate

Is the service safe?

Our findings

People gave mixed views when asked if they felt safe with the staff that cared for them and the service they provided. One person said, "I do not feel safe with the carers particularly the new ones. The young carers are sharp and talk nastily with me." Another person said, "The carers with whom I felt safe are not given in spite of me making repeated request." A third person said, "I feel safe when the carers come. They are polite and nice." One relative told us their family member was safe with the care workers that cared for them.

Some of the people told us they had felt neglected, as they had received no call, or their call had been later than arranged. Some reported the timing of the calls they received were erratic with no set times adhered to. We found the times arranged for people's calls had been changed at short notice. This meant people were unsure who would be visiting them as the service did not always contact them when changes arose.

People told us on occasions they had received no call at all. One relative told us on two consecutive days the care worker did not arrive to their evening call to assist their family member to go to bed. They told us the person had to struggle and put themselves in bed. The person's care plan stated the person had mobility issues and as a result there was a risk the person may fall or injure themselves. On another occasion the person's relative told us the family member did not receive their agreed call which was agreed to be between 8pm and 9pm. They said, "The care worker did not arrive until 10.50pm," which was approximately two hours later than the original call. This meant people's safety was placed at risk and they were not protected from avoidable harm.

A person told us about the impact of receiving late calls. They said, "I am on morphine and control medication at certain times otherwise I am at risk with an overdose. I am supposed to be taking them at a regular interval as advised by my GP." They told us in one month they could get five different carers. They said "The regular carers are on time and wait for my medication to be given at the right time. The new carers who are young are never on time. I have to tell them what they need to do. I am not sure what time they are given, but my social worker has allocated 45 minutes in the morning and the carer's spend ten minutes and want to go." They said, "The new ones turn up at 7.45am instead of 7am." The irregular time patterns of staff arrival to calls, or when staff do not turn up at all, places people's safety at risk.

There were systems in place to manage the care calls people were allocated to receive, however the coordination of these calls were not managed appropriately. There were a number of safeguarding issues raised by the local authority that identified inappropriate call times and management of the care. This showed the service was not managing the care and support in a safe way.

We found the registered person had not protected people against the risk of people receiving care or treatment that was inappropriate or unsafe. This was a breach of Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulation 2010, which corresponds to Regulation 9 of the Health and Social care Act (Regulated Activities) Regulations 2014.

We found although the provider had systems in place to identify the possibility of abuse and prevent abuse from happening people were not always protected. People received late calls and on some occasion no call at all, which left the person in an unsafe situation. We saw policies and procedures were in place for safeguarding adults and staff told us they were aware of the policies. One staff member told us they were given copies of the providers safeguarding policy and procedures when they first started work with the service.

Staff told us they had received safeguarding training as part of their induction, but there had been no follow up or on-going training. The manager told us they were not up to date with safeguarding training, but this had been booked. Staff we spoke with had an understanding of how to recognise the possibility of abuse and how they should keep people safe. One staff member told us they would report to their line manager in the first instance, but lacked understanding of reporting to the local authority safeguarding teams.

People had their individual risks identified prior to receiving their care package. The care coordinator told us they did not always get the relevant information when the package first started from the local authority. However, they had a system in place to obtain this information. A senior member of staff told us care plans and risk assessments were kept in people's homes. However, people and their

relatives told us this was not always the case. The senior staff member also told us staff could also access a copy of a risk assessment through their phones. The service had in place a phone application for staff to receive up to date information regarding a person who used the service. Staff we spoke with confirmed they received information relating to a person they cared for by their phone. However, we found the phone application required updating or refreshing regularly. If this process was not completed the impact on the person meant they were at risk of not receiving their call.

We saw there were plans in place for emergency situations and the manager told us there was an out of hours system in place to ensure staff and people who used the service were supported. We found and people told us this was not always effective as people's calls were still missed, late or at irregular times.

People we spoke with didn't comment on the numbers of staff at the service. We looked at staff rotas and found on the majority of occasions the number were sufficient to ensure that people were safe. When we spoke with staff they told us there were times they had to provide cover at short notice. One staff member told us they felt there were enough staff, but not all the time. Another member of staff told us there was not sufficient staff in all areas and there were times, especially at weekends where they had covered other care runs across different areas. They said that sometimes there wasn't enough time to attend the calls. This showed there was a risk people's needs may not be met as staff had insufficient time to complete the call.

People gave us mixed comments and views about the suitability of the staff. One person said, "I am given different carers and the new ones. I have to tell them what they need to do and still they don't do it." Another person said, "They do not know the job as I tell them they have to shower me." One person told us the staff were not always their regular care workers, but they said, "All of them know what care was needed." This showed there was an inconstancy to safe care being delivered.

We saw the provider had processes in place that ensured safe recruitment procedures were followed to make sure people were suitable to work with vulnerable people.

We found the service followed clear disciplinary procedures when identifying staff who had been involved with unsafe practices. The registered manager took appropriate action and put plans in place to ensure people were kept safe.

People told us they did not always receive their medicines safely and as prescribed. One person said, "I get confused with taking my tablets as the care workers mess with my call times and then rush to another job without giving me my medicines." Two people we spoke with told us the time they received their medicines was really important, but the call times were either missed or irregular, which impacted on the time they should take their medicine and in a safe way. Another person said, "I have to take breakfast and then tablets on time, but the carers are never on time."

A relative told us they had checked the records stored in their family member's home and noted that medicines were not always given as stated in the care plan. They told us on one occasion it was recorded in their daily record that the care worker had given the medicine to their family member, but the care worker had not witnessed the person take the medicine as another care worker on the next call had found loose medicines next to the person. The persons care plan stated 'Care staff to prompt and witness medication being taken by [name of person]. This showed people were not given their medicines safely.

We found one person was taking covert medicine and their care plan had appropriate instructions for staff on how to do this. The medical advice from the GP stated medicine was to be taken in food, but did not stipulate what sort of foods. When we looked at the person's care plan we found no advice from a pharmacist had been sought until we prompted the manager to do so on the day of our visit. There was a risk the medicines could have been ineffective.

We found people were supported to take their own medicines and this was documented on their care plan and confirmed by the people we spoke with. One person who required support with their medicines told us their regular carer workers were on time and wait for their medication to be given at the right time. Staff told us and we saw recorded in the care plans that medicines were stored safely. In one care plan we saw that discussion had taken place with family members to arrange for a secure cupboard in the person's home so medicines can be stored correctly and safely. Staff also told us they had received training in how to administer medicines safely. They had a good understanding of how to complete records correctly

Inadequate

Is the service safe?

and we saw some records had been completed with no gaps in the medication records, but the manager told us they did not complete any audits to ensure this was done constantly and in a safe way.

Requires improvement

Is the service effective?

Our findings

Not all the people we spoke with felt the staff had the required skills to support them. Some people were complimentary about the staff and felt they could not fault them. However, some people gave examples where they had needed to tell the staff what task they should complete. Others told us it was better when they had the same care staff on a regular basis.

We spoke with the manager. She told us they were rearranging most of the care schedules and this was still on-going. They said there had been a lot of disruption to peoples care packages due to an excessive amount of new care packages through an update to their contract with the local authority and they were trying to address this issue.

We looked at one person's care plan to see if their day to day health needs were supported and if the care they received was effective and relevant to their needs. We found the person had a number of complex health needs, such as, diabetes, high cholesterol, a history of heart attacks, and asthma. One care plan stated the level of medication support the person required. We spoke with a relative of the person, they told us the persons medicines were time specific, but the person did not always receive their care call at the same times to ensure their care and support was effective. The relative told us that on one occasion staff had not given the persons there medication in sufficient time for the treatment for their day to day health to be effective. There was a risk people may not receive effective care relevant to their needs.

We looked at another care plan where the person was at risk of falls and obtaining pressure sores to their skin, but there was no guidance for staff in place regarding this. Staff had no instructions to follow if the person should have a fall or their skin integrity should deteriorate. This showed the service was not assessing, managing or monitoring people's health needs effectively.

We saw care plan reviews were taking place, but no one had identified that relevant information to help support the people's needs were missing. People were not full supported by the service to ensure they maintained good health.

We found the registered person had not protected people against the risk of people receiving care or treatment that was inappropriate or unsafe, by means of the effective operation of systems. This was a breach of Regulation 10 Health and Social care Act 2008 (Regulated Activities) Regulation 2010, which corresponds to regulation 17 of the Health and Social care Act (Regulated Activities) Regulations 2014.

Most people felt staff were trained to do their job, One person said, "My regular carers are trained as they tell me so." Other people commented that some staff did not know their job or fully understand what was expected of them when completing tasks. This showed there was inconsistency on staff being fully trained or competent to provide people with safe care.

We saw six staff were attending an induction on the day of our visit. When we spoke with them they told us they felt the induction training was the best they had had and that they felt it was very robust. We spoke with the trainer who told us staff completed a number of work books and had to be signed off as competent before they were able to support other experienced care workers when providing care for people. This meant people would be supported by competent staff who had completed a robust induction to their role.

The manager told us the care coordinators were to also receive further training regarding their job role. We saw this training had been rolled out at other locations, but was still to be implemented at the service at the time of our inspection. This meant people's care was managed by staff that did not fully understand their role as full training had not been completed.

One staff member we spoke with said, "I have attended staff meetings and feel able to raise any concerns with my manager." Staff also told us they had received supervision, but not on a regular basis. The manager told us they normally completed supervision every six weeks, but due to the new ways of working this had not been completed. Staff files we looked at did not contain any up to date supervisor notes. Staff competences were not assessed, reviewed or adjusted to meet the changing needs of people to ensure they received effective care.

People told us staff asked their permission and sought their consent before they provided care.

We looked at four care plans and saw people had given their consent by signing documentation to say they agreed to the care and support they received from the staff. One care plan we looked at identified that the person was

Requires improvement

Is the service effective?

unable to sign and it was recorded that verbal consent was obtained. We also looked at another eight care plans and none of the people had had their mental capacity assessed to make sure they were able to make informed decisions about their care. There was no information to identify if people had contributed to the planning of their care. Two care plans we looked at had a Mental Capacity Act (MCA) assessment completed, but these had been signed by the person's relative. We found no consent or power of attorney on the persons file to say they were able to do this. The Mental Capacity Act 2005 was introduced to protect people who lack capacity to make decisions, because of illness or disability. However, the lack of this information showed people were not fully consulted or correct procedures were not followed to ensure consent was given appropriately.

Staff we spoke with told us they were aware of the Mental Capacity Act (MCA) 2005 and had received training in this area as part of their induction and were aware that it meant they needed to give people a choice in the way they wanted to live their life.

People told us the care workers provided them with support with eating and drinking. One person said, "They [care workers] make me a drink if I want one." However we found staff did not always make sure that people were eating and drinking enough to keep them healthy. In one care plan we looked at there were details of the support the person required, but it was not documented what that support should be or how this should be provided. The care plan also stated the person had lost weight recently, but there was no information to describe what food or drink the person should have to maintain their body weight. Although people received a nutrition assessment not all the assessments were fully completed or contained sufficient details to ensure people's nutritional needs were monitored regularly. We saw what food and drink one person should receive, but found the person was at risk of choking; however there was no risk assessment to what staff should do should the person choke.

We had two concerns raised from relatives who told us their family member was at risk of being given out of date food by staff who supported them. They told us the care plan had identified staff should support the person by checking and disposing of out of date food in the fridge. However, when we looked at the person's food and nutrition care plan there were no instructions regarding checking the person's fridge for out of date food, but it did state staff were to support the person with shopping. We looked at the 'person centred summary sheet' for this person and it stated 'prepare a shopping list and ensure that dates are checked on items already in the kitchen.' This showed that where the service was responsible for what people had to eat and drink they did not always monitor the process sufficiently to eliminate the risks for people's health.

Staff told us there were times when they had assisted people and call for medical assistance. Care records we looked at showed that where necessary, staff supported people and made referrals appropriately to other healthcare professionals. However, when we looked at the daily notes and one person's care plan recommendations had not been taken into account. This showed the service did not act on the recommendations and guidance from other healthcare professionals to ensure people received effective care.

Requires improvement

Is the service caring?

Our findings

Some people and their relatives told us that staff treated them with kindness and respect and most were content with the way in which they were treated by the care workers. One person said, “The carers are not regular, but all of them know what care I need. I cannot fault them at all.” Another person said, “The carers are regular ones and kind and respectful and maintain my dignity.”

Some people commented on how well the staff treated them. One person said, “The carers are very, very good.” Another person said, “The carers are very good, can’t complain. A relative told us their family member had a good rapport with the care workers as they told them what was happening and kept them informed at all times. However, we received negative comments when we asked people if they received the same care worker or if they stayed for the duration of their care call. Most people told us the care they received was inconsistent. Other told us staff were sometimes rushed and wanted to get to their next job. One person said, “They [staff] cannot stay long enough and have to go.” Other people told us that they would get to know a member of staff and feel comfortable with them and then they would change and you would not know who is coming to care for you. This could cause people to become stressed and confused.

People told us they were involved with the planning of their care and making decisions about their care needs. One person said, “I am having a review of my care next week. I have been informed someone is visiting me.” Another person said, “My care plan is reviewed every year and I am involved in it. I read it and sign it.” Care plans we looked at showed that people were involved in the planning of their care. Two relative told us they were involved with decisions about their family member’s care, but felt the communication and information they received from the office was insufficient. One relative said, “The carers are ok, but the office staff try to fob you off. You can ring for hours and get no response.”

We asked the manager if people were given information about advocacy services to help them when they needed support for someone to speak on their behalf. Advocates are trained professionals who support, enable and empower people to speak up. The manager told us they did not promote this service at the moment, but would supply information if people asked for it. She said staff were knowledgeable and were encouraged to report to the office if they felt someone may need this service. Staff told us they would contact the office if they felt someone needed someone to speak on their behalf.

People were supported by staff who were aware of their individual communication skills and some of their preferences. However, not all people had good experiences of this. One relative said, [person name] had requested no male care workers, but the office sent a male on one occasion. This upset [person’s name] and caused them distress. A staff member told us about a person they cared for who only liked female care workers providing their care. Another member of staff told us that it was written in the person’s care plan what they liked and disliked. This showed the service were not always listening to people and taking account of their preferences

People were not always treated with dignity and respect. We received mixed comments when we asked people if their dignity was maintained and if staff respected them. One person said, “They wash me, sometimes they shower me, maintain my dignity and respect me as well.” A relative told us they maintained their family member’s dignity and respected them each time they provided care. However, another person described how staff did not dry them after a shower and how they felt staff treated them in a way that did not support their dignity.

Staff told us they had been trained in how to respect people’s privacy and dignity. We found most staff understood how to put this into practice and promoted people’s independence by supporting people to do things for themselves and participate in daily living tasks to develop their independence. One staff member said, “I encourage people to be independent, for example one person is able to wash their own face so I give them the flannel, so they can do this.” Staff we spoke with described how they ensured the delivery of care was completed in a caring way. They were able to describe the care they provided to each individual they cared for. One care worker described how they ensured people were treated respectfully. They told us they gave people choices and treated them with respect and respected the person’s wishes. Other staff we spoke with felt there was not enough time between calls to ensure they could spend quality time with people.

Requires improvement

Is the service responsive?

Our findings

People we spoke with were not confident staff would respond to their needs in a timely manner. We received mixed comments from people and their families regarding how the service responded to their needs. Some people felt the service provided inconsistent care.

People told us they felt they were not always at the centre of the care they received as sometimes staff focused on the tasks they were doing rather than them as an individual. Other people felt the care and response times had been better, but there were shortfalls in the way the service had responded to people especially if the care worker had failed to make the call or was running late.

We received concerns that one person should have received four calls per day, but the service failed to deliver these calls. The person's relative described how their family member was left with no support for a whole day. They told us the person was found in an undignified way. This showed the service failed to provide effective care and support for this person

We found the registered person had not protected people against the risk of people receiving care or treatment that was inappropriate or unsafe. This was a breach of Regulation 9 Health and Social care Act 2008 (Regulated Activities) Regulation 2010, which corresponds to regulation 9 of the Health and Social care Act (Regulated Activities) Regulations 2014.

People told us that they had received many different care workers throughout the week, especially when their permanent care worker (if one had been allocated) was on annual leave. One person told us they had missed their usual visit to a day centre on two occasions, because the care worker arrived later than the time they had requested and arranged their care to be provided.

We saw some pre-assessments had been undertaken by the service and some from the local authority. The manager told us assessments were carried out with people and their care plans were arranged to suit their needs. We saw not all care plans were person centred, but staff were able to describe how people received person centred care. We looked at care plans and we found discussions had taken place around the people's life history, but information was not sufficiently detailed. This meant staff would not be familiar with the person's interests or hobbies or understand what may be important to them.

We saw in the care files we looked at that annual reviews of care had taken place and it was identified if the person or a family member had been involved. People knew when they had their care reviewed or if this had been planned.

People were aware of how they should make a complaint or raise a concern, but felt the service did not always take their views fully on board or change the practice to improve the service. One person told us they raised a concern, but nothing had improved. Another person told us they raised issues with the service, but it was not until they raised it with the CQC that the issue improved.

We found the process for managing and monitoring complaints was inconsistent. We saw the system which logged people's complaints, but they were not always tracked or monitored to ensure there was an audit trail. Staff had an understanding of what they should do if a person raised any concern or made a complaint to them. Staff told us they were aware of the procedure they should follow and who they should report to. We saw policies and procedures were in place and up to date. However, the complaints process was not always followed as stated in the provider's policy and procedure. People did not always receive a response in a timely manner.

The manager told us they had received a number of complaints in the last 12 months. We found the provider's policy and procedures had not always been followed. We saw that some action had been taken, but received a number of concerns from people that the service had not responded back to them. We raised this with the provider and they addressed the issues we raised. We found when appropriate the provider's disciplinary process had been opened and followed accordingly.

We found the registered person had not protected people against the risk of people receiving care or treatment that was inappropriate or unsafe, by means of the effective operation of systems for complaints. This was a breach of Regulation 19 Health and Social care Act 2008 (Regulated Activities) Regulation 2010, which corresponds to Regulation 16 of the Health and Social care Act (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

People told us they did not always receive enough information on how the service was run. Some people mentioned an information folder, which was kept in their home. Other people told us they had no information about the service or their care. We spoke with the manager and they told us they were in the process of addressing this issue. We were told each person should have a copy of the service user guide. The manager told us some of the information was out of date and they would be resending a copy to all the people who received care once it was updated. This meant information that was shared was inconsistent. Some people had inaccurate information, which could impact on how they received their care.

People and their relatives told us they had requested a care call rota as they wanted to know who was coming to their home. Some people said this had been supplied, but only after they had insisted. Other people told us they had the rota, but there were gaps in the rota as the call had not been covered at the time the rota was sent out. This showed the rotas were not managed according to people's needs.

Some people told us they had completed questionnaires about the service they received. However, other people raised concerns that they were not asked about their views of the service. One person said, "The office has never asked for feedback in all the years I have had care." Another person said, "The office never calls." We saw documented evidence that showed people who used the service could express their views by completing a service questionnaire. We saw a copy of the last quality survey. We found the comments were mainly positive, however this did not reflect the views of all the people who used the service. This showed there were inconsistent monitoring systems in place.

Systems were in place to monitor the care calls, but from information we received and from what people told us these systems were not effective. People and their families were contacted by letter to inform them the provider was implementing their own electronic call monitoring system along with one used by the local authority. This was to make sure calls were covered in a timely manner and make the service provided more effectively run. We found these systems were monitored, but they were not always effective to make sure people received their care in a timely manner.

We saw the provider undertook a site visit and monitored the service on the same day of our inspection. The report told us that the provider had found shortfalls similar to our findings. An action plan was implemented, but it was too early to tell what improvements if any had been made.

There were procedures in place to monitor and improve the quality of the service provided. The manager told us that they contact staff via telephone, and text as staff had use of company mobiles. Staff we spoke with confirmed this. Care coordinators told us they conducted spot checks and observations of care, but these were not up to date. This showed monitoring systems that were in place were not effective.

Staff we spoke with confirmed they received contact from the office and management to ensure they were supported to provide care and support to people who used the service. However, one member of staff said, "Messages are not always passed on, especially out of hours."

People told us they felt communication with the office was inconsistent. The service user guide states that people were responsible for contacting the office if a care worker was late or does not arrive to provider their care. The provider told us they had identified this as an issue and put systems in place to make sure more incoming phone lines were available. We requested information that evidenced improvements had been made as the area manager told us they were monitoring the system on a daily basis. We have not received this information to date.

We found the leadership to be reactive and the way the service was managed did not always identify all the risks. There were no strategies in place to ensure the service ran smoothly.

There was a registered manager in place, but there was a lack of communication and involvement regarding the day to day running of the service. Roles and responsibilities were not clear and the management team had not developed the staff team sufficiently to ensure they were aware of what they were accountable for.

We found reviews were not always carried out for care plans, training, daily notes and medication administration

Inadequate

Is the service well-led?

records. One person commented that it was four years since their last care plan review had taken place. The manager told us they had not completed audits and care reviews were not up to date. They told us there had been a lot of changes with working practices and new contracts. They told us they wanted to ensure all people received care before the reviews took place. There was a risk people would receive inappropriate care as care plans were not updated.

We found the registered person had not protected people against the risk of people receiving care or treatment that was inappropriate or unsafe, by means of the effective operation of systems. This was a breach of Regulation 10 Health and Social care Act 2008 (Regulated Activities) Regulation 2010, which corresponds to Regulation 17 of the Health and Social care Act (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. 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 **Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010**, which corresponds to regulation 9 of the Health and Social care Act (Regulated Activities) Regulations 2014. **9**(1) The registered Person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of— (b) the planning and delivery of care and, where appropriate, treatment in such a way as to— (i) meet the service user's individual needs, (ii) ensure the welfare and safety of the service user.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010**, which corresponds to regulation 17 of the Health and Social care Act (Regulated Activities) Regulations 2014. 10 – 1 The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to— (a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and

This section is primarily information for the provider

Action we have told the provider to take

(b) Identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

(2) for the purpose of paragraph (1), the registered person must-

(b) have regards to –

(i) the complaint and comments made. And views (including the description of their experiences of care and treatment) expressed by service users, and those acting on their behalf, pursuant to sub paragraph (e) and regulation 19.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010**, which corresponds to regulation 16 of the Health and Social care Act (Regulated Activities) Regulations 2014. 19 – 1 For the purpose of assessing, and preventing or reducing the impact of, unsafe or inappropriate care or treatment, the registered person must have an effective system in place (referred to in this regulation as "the complaints system) for identifying, receiving, handling and responding appropriately to complaints and comments made by service user's or persons acting on their behalf, in relation to the carrying on of the regulated activity. (2) In particular, the registered person must- (c) ensure that any compliant made is fully investigated and, so far as reasonably practicable, resolve to the satisfaction of the service user, or the person acting on the service user's behalf; and

This section is primarily information for the provider

Action we have told the provider to take

(d) take appropriate steps to coordinate a response to a complaint where that complaint relates to care and treatment provided to a service user in circumstances where provision of such care and treatment has been shared with, or transferred to , others