Cure Healthcare Services Limited

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Inspection report

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Date of inspection visit:
25 June 2019
26 June 2019
27 June 2019
01 July 2019

Date of publication:
12 August 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Cure Healthcare Services Limited is registered to provide personal care and support to people in their own homes. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of the inspection the service supported 38 people across Buckinghamshire and Slough area.

People's experience of using this service and what we found
People were not always protected from the risk of harm. Staff did not routinely have access to information on how to support people with their medical conditions. People were not always supported by staff who had been recruited safely. People were put at risk due to unsafe recording practice for medicine management.

People did not always have the support they had expected. People told us when they required two staff to support them this was not always provided. Comments from people included, "Two don't always come and the one is on the phone trying to find a second person," "The carer had not been informed that [Name of person] had been in hospital and she now needed two people" and "They stay to my satisfaction, but the double ups [two staff] have been a problem."

People told us they were not routinely supported by a dignified service. People commented they struggled to understand care workers. Comments included "They [Care staff] talk so fast it's hard, it's a job to understand" and "They do try and talk to mum, and they smile a lot, but English is a problem."

People did not have their human rights routinely protected. The service did not routinely support people in line with the Mental Capacity Act 2005. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People were supported by staff who did not have a regular one to one meeting or an annual appraisal of their performance. No formal system was in place to ensure staff received training when required.

People told us they were not happy about the service received. Complaints to the service were not routinely recorded or fully investigated.

There was a lack of clear management within the service. We found ongoing concerns about record management and quality assurance processes. Audits completed did not drive improvement. Daily records written by care staff were of a poor quality. People told us "There's no detail about the person in the report it's just repeated sentences around the jobs they have done" and "The statements are very limited in the book, they don't have a descriptive English."

The registered manager did not regularly attend the office, care staff did not meet with the management. We have made a recommendation about this in the report

The service did not learn from when care was not delivered as planned. We found the service did not routinely record actions taken following feedback. We have made a recommendation about this in the report.

Rating at last inspection and update
The last rating for this service was requires improvement (published 4 May 2018) and there was a breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough, improvement had not been made or sustained and the provider was still in breach of regulations.
This is the second consecutive time the service has been rated requires improvement since it registered with us on 13 February 2017. This is our second inspection of the service.

Why we inspected
This was a planned inspection based on the previous rating.

We have found evidence that the provider needs to make improvements. Please see all the sections of this full report.

Enforcement
We have identified multiple breaches in relation to safe care, person centred care, staff recruitment and training, compliance with the Mental Capacity Act 2005, the management of complaints, the good governance and management of the service

Please see the action we have told the provider to take at the end of this report.

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.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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 always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Cure Healthcare Services Limited

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience (EXE) is a person who has personal experience of using or caring for someone who uses this type of care service. The EXE made telephone calls to people and their relatives.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

At the start of our inspection the service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, during our inspection process they made an application which was successful to de-register. The service did not have a registered manager in post from the 4 July 2019. However, in the report we have referred to the registered manager as they were present at the time of the site visits.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 25 June 2019 with telephone calls to people and their relatives. It ended on 2 July 2019. We visited the office location on 26, 27 June 2019 and 1 July 2019.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

We looked at information we held about the service and what people had told us. We contacted local authority safeguarding teams. We used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and 10 relatives about their experience of the care provided. We spoke with nine members of staff including the provider, registered manager, office manager, relationship manager and care workers.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at six staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We contacted staff to seek further feedback about their experience.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- People were placed at risk of harm due to incomplete medicine administration records.
- The provider had a policy (dated 5 January 2019) detailing how staff should support people. This included what needed to be recorded to ensure safe administration of medicine. National guidelines (NICE NG67) had been produced for providers to follow when care staff were required to support people in their own home with medicines administration.
- Medicine administration records (MARs) used and completed by the provider did not follow national guidelines or the providers own policy. Care staff hand wrote onto the MARs, they did not routinely include the name of the prescribed medicine, the dose, route or frequency. For instance, we noted one MAR stated, "Pink inhaler", another MAR stated, "Eye drops". This placed people at risk of not receiving the required medicine as prescribed.
- Some people were prescribed medicines for occasional use. No additional guidance was available for staff on when and how to administer these.

We found no evidence that people had been harmed. However, the provider had failed to ensure medicine records were accurately completed to ensure people were protected from avoidable harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Where people required support with their medicine this was detailed in their care plan.
- People we spoke with did not raise any concerns about how they were supported. One person told us "They are good at writing up the medicines."

Staffing and recruitment

At our last inspection we recommended the provider sought guidance about ensuring robust recruitment processes were in place. At this inspection we found the provider had not made the improvements required.

- People were not supported by staff who had been recruited safely.
- The provider did not ensure all staff applications included all the required checks stated in the relevant Regulation.
- The provider failed to routinely seek references from the potential staff's most recent employer. Gaps in employment were not routinely explained. Reasons for leaving employment was not always sought and most recent photos of staff were not in all files viewed.

The provider had failed to ensure people were supported by staff with the right character and attributes to provide safe care. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Staff told us they recorded and reported any safety concerns.
● There was a lack clarity across the management team as to what action was required following a report being made. No formal investigation process was in place.
● Accidents and incidents were not routinely analysed to look for themes and trends. We discussed this with the registered manager and provider who confirmed this did not routinely happen.
● The provider had informal meetings with office staff to discuss how they could improve the service. The meetings were not recorded and action resulting from them could not be measured or accounted for.

The providers internal audit processes did not drive improvement in the service. The culture within the service did not demonstrate lessons were routinely learnt when things went wrong. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing risk, safety monitoring and management
● Prior to supporting people, the provider carried out a number of risk assessments. These included, medicine, home environment, falls, moving and handing.
● Risks posed to people as a result of their medical condition were not routinely assessed. For instance, one person was a diabetic. No risk assessment was in place for the management of the medical condition.
● No additional information was readily available to staff on the condition. We read in the person's daily notes a carer worker had recorded the person complained of feeling dizzy. The note went onto read "I have told her not to have any sugar". This could have been a sign of low blood sugar and therefore the person would have required a sugar-based item. We discussed this with the registered manager. They provided us with guidance which was going to be sent to staff.

The provider failed to adequately assess risks posed to people. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were supported by staff who had received training on how to identify, report and protect people from abuse.
● Staff were able to demonstrate their learning. Comments from staff included" I would make sure they were safe and report it to my office" and "You have to recognise, record and report."
● Office staff were aware of the need to report any safeguarding concerns to the local authority. However, they did not always report the concern to us.

Preventing and controlling infection
● People were supported by staff who had received training on how to minimise the spread of infections. Staff who supported people with food preparation had received training in food safety.
● Staff had access to personal protective equipment (PPE), such as aprons and gloves.
● People had told the service care workers left their property in a clean and tidy state. This was routinely feedback to the service in questionnaires returned by people.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes, an application can be made to the Court of Protection who can authorise deprivations of liberty. We checked whether the service was working within the principles of the MCA.

At our last inspection we recommended the provider sought guidance about the requirements of the MCA and its associated code of practice. At this inspection we found the provider had not made improvements required.

- The service identified if people had difficulties making informed decisions. However, they did not routinely carry out a mental capacity assessment when concern about their ability to make decisions were highlighted.
- The registered manager had carried out a mini mental assessment (MMSE) a nationally recognised 30-point test to measure memory impairment. The person had scored five out of 30, demonstrating they had severe memory loss. However, no capacity assessment had been completed for the decision to receive care and support. We noted the person regularly declined support from care workers.
- The service had recorded third parties held legal powers to act on behalf of people. However, they did not check the validity and only accepted verbal feedback from relatives. Family members were asked to sign consent forms for their relative.
- The person's best interest must always be paramount when third parties make decisions on their behalf. The code of practice for the MCA clearly states how a best interest decision should be recorded. We found the service did not routinely record or hold best interest decision meetings or discussions on behalf of people who were unable to consent to care and support.

The service did not routinely support people in line with the MCA 2005. This was a breach of Regulation 11

(Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had a policy of the implementation of the Mental Capacity Act 2005 dated 5 January 2019. Staff had received training on the MCA. Staff were able to communicate their understanding of the MCA. Comments from staff included, "Mental capacity is about trying to support people to make their own decisions. I encourage people to make their own decision, I don't force them."

Staff support: induction, training, skills and experience

At our last inspection we recommended the provider sought guidance about the supervision and appraisal of staff. At this inspection we found the provider had not made improvements required.

● The service had a supervision policy dated 5 January 2019. It stated staff should receive "A formal supervision at 3-monthly intervals". We found this was not the case. One person had been employed since 2017, they had one recorded supervision meeting on file.
● We found other staff files did not contain evidence of three-monthly supervision meetings with a line manager.
● Staff received induction training and ongoing training. However, this was not always updated in line with the timescales expected by the provider. The registered manager delivered mandatory training. They told us training was not updated regularly. We were provided with a training matrix which confirmed refresher training was overdue for several staff members. No system was in place to ensure staff received refresher training when required.
● People told us they did not have confidence staff were well-trained. Comments included, "Some don't have much of a clue, but I can explain… understanding can be an issue," "Their training is giving them a list as long as your arm of what they can't do" and "You can't train someone to care."
● Staff gave us mixed responses about how they were supported. All staff we spoke with told us they received induction training but were waiting for training dates to be confirmed. Staff told us they had not received regular one to one meetings. One member described the registered manager as "Hard to find, they are not really a day to day person." Staff were complementary regarding the support they had received from a newly appointed office manager.

The service did not routinely supervise or appraise staff in line with their own policy. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Prior to a person receiving support from the service a full care needs assessment was carried out. The assessment gathered information about the person's physical and mental health, communication and social history as examples.
● Where the assessment identified a need for equipment this was in place prior to care starting. For instance, if people required support to reposition a hoist was in place.
● Assessments identified any individual needs which related to the protected characteristics identified in the Equality Act 2010. For instance, preferred language, faith, religion, and cultural considerations.

Supporting people to eat and drink enough to maintain a balanced diet
● Where people required support with meeting their nutritional needs this was detailed in their care plan.
● We received mixed responses from people about the support they received with meals. Positive comments included "All the food has to be pureed and that is done well," "They put the food out so that I can do it as I like to" and "They help her to get her breakfast which keeps her independence a little bit."

● Negative responses included, "They make her a drink but don't stay to see she drinks it and then the next one does the same," "[Name of person] can't chew so everything is blended but when they feed her it's huge spoonful's because they want to be done and off. She hasn't choked, yet" and "Most were unable to cook, and one went miles away to goodness knows what kitchen, had someone else cook and brought it back in containers for him."

Staff working with other agencies to provide consistent, effective, timely care;
Supporting people to live healthier lives, access healthcare services and support
● People were supported to maintain their health. The service made referrals to external healthcare professionals when required. For instance, to occupational therapy and district nursing services.
● People told us care staff responded to changes in their health. Comments included, "I was feeling poorly on Sunday and they called the GP then an ambulance and I had to go to hospital,"
"They did suggest I called the GP after my fall, but it was two days before Christmas and I was not going to spoil my families Christmas and I was OK" and "I was feeling poorly but they knew that I don't want to go to hospital, it's something that we have talked about."
● We saw the service reported concerns to the local authority where changes had been identified in people's level of need.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People told us they did not always know which care worker was visiting them. People told us, and the service confirmed no information was sent out regarding which care worker had been booked for each call. One person told us "I did ask for a rota but was told I couldn't have one, it leaves us with no idea who's coming." Another person told us "Carers do not know who is coming next if it's not them so cannot give information to the person."
- Some people who had regular carer workers spoke highly of them. One relative told us "[Name of person] has wonderful support, this is the best it has been in years."
- Other comments included, "I have a regular group of two and I usually know the person who covers if they are off," "[Name of staff] bought me a lovely cup at Christmas with princess [Name of person] on it. She calls me princess and I call her 'your majesty'. We get on really well, always making me smile" and "The two at the moment are kind and adaptable." A relative told us "They have treated my mum as I would and that's lovely, they are super."
- People told us they did not always feel respected in their own home. People commented care staff were not always able to communicate effectively with them. Comments included "There are people from most nations, English is rarely a first language and that just adds to the issues of this whole set up," "Some just don't understand English and you can't read what they have written in the report book," "I would describe their English as fractured."
- Other comments included "They [Care staff] talk so fast it's hard, it's a job to understand" and "They do try and talk to mum, and they smile a lot, but English is a problem."

Supporting people to express their views and be involved in making decisions about their care

- Staff were not supported to provide care and support as people liked. Office staff who scheduled care visits did not allow enough time between calls for staff to travel. People told us they did not always have calls at the times they wanted. Calls to people were often late as a result.
- People told us staff did not always have time to listen to them. People said "They do the minimum they can get away with because they have to rush off, if there were more of them in different areas it wouldn't be so bad" and "One or two have got to know me but the big horrid thing is when they are in a rush and keep telling me to 'hurry up' but I can't hurry and get all bothered. I don't want to hold them up."

Respecting and promoting people's privacy, dignity and independence

- We received mixed responses from people and their relatives. People and their relatives told us they were not always given dignity and privacy. Negative comments from people included "They don't think, folding

up wet nighties to be worn later. Not changing wet bedclothes. I have to guide the carers to give her more privacy, using towels so she's not completely naked. Telling men to stand behind rather than staring at her. The men distressed her, so we have stopped them now" and "Nobody goes the extra mile, they do their job," "They treat her as a job" and "The [Nationality of care worker] lady gets annoyed with me. When I ask a question her usual answer is that she doesn't know, she's not a GP I try and please her. She does say good morning, but she's in and out."

● More positive comments from people included, "They have been wonderful. After my Mum died they came and offered their condolences. They are very kind to my father," "The weekend people treat [Name of person] with great respect, better than in the week," "A couple are lovely and when they come it's a good day" and "It's a good job that they speak Italian because [Name of person] doesn't speak Romanian and neither she nor they speak very good English, it sort of works."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People told us they did not receive a personalised service. People who required two staff members to support them were not always provided with two care workers. People told us "Two don't always come and the one is on the phone trying to find a second person," "The carer had not been informed that [Name of person] had been in hospital and she now needed two people" and "They stay to my satisfaction, but the double ups [Two staff] have been a problem."
● A relative told us "They don't always come and because I have always cared for my wife they know that I will step in. They didn't send two people on 21 March, 31 March, 18 April and 26 April 2019. When the first carer rings the office they say someone will come but not when and as the first doesn't want to be late for the next call she asks if I will help, she rings the office again and tells then that I am willing but they never acknowledge that they are not fulfilling the contract and then they charged me for two people."
● People told us they did not always have the support at the time they had requested. Comments included "We agreed a time of 7am but she [Care staff] will say that she wants to come at 6am which is difficult for me, my alarm hasn't even gone off so I have to get up in a hurry and that worries me," "They are always in such a hurry and today she left before I had come down the stairs and she's meant to make sure I make it to my chair but she said I was too slow and she was too busy" and "One was really late and when I rang she had the right road but had gone to the wrong town, I told them not to bother."
● People told us they did not always get told if a carer was going to be late or if the service was unable to send a care worker. People said "I waited until 10:45 one time, then I called and eventually they rang back and said there had been an emergency, that's happened twice before," "I've called them so many times about poor time keeping" and "We had to put [Name of person] to bed as they were due between 6:30pm and 7pm but nobody by 8:45pm so we did it. It's because they were coming from a long way away." Another person told us "Nobody phones if they are going to be late so you are just left not knowing."

The service did not routinely provide support as detailed in people's care plans, which placed people at risk of harm. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Each person had a care plan in place, which recorded their likes and dislikes. The care plan included a brief social history of the person. People told us the care plans were not always reviewed. One person told us "I have an elaborate care plan, but they don't stick to it. I think it's written to get our business. It's never been reviewed."

● Care plans detailed how people wanted to be supported. Where people required the use of equipment to support them move position, this was recorded.
● Care plans detailed people's chosen faith and religion and what support if any they required in observing them.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● The service recorded people's communication needs. This included speech, hearing and sight difficulties.
● Where people required support with their communication this was detailed. For instance, one person's assessment stated communication was more difficult when they became tired. Staff were guided to give the person more time when this happened.

Improving care quality in response to complaints or concerns

At our last inspection we recommended the provider made sure its complaints policy was available to all people. At this inspection we found some improvements had been made. However, we found ongoing concerns about how complaints were dealt with.

● We looked at completed questionnaires sent to people. We found people routinely feedback that they had access to information on how to complain. People said they were confident to complain about the service received.
● People told us "I complained about being left for six and half hours because they were early for the morning call and late for the next one. They rang me back about that," "I have complained about the poor timekeeping, when they turn up and how long they stay and the fact that they communicate with us very poorly. It's all been done on the phone so no records" and "I have twice complained about carers coming late."
● We found the service did not follow its own policy on how to handle complaints. Records relating to complaints were incomplete and did not demonstrate the complaint had been acknowledged or investigated. We bought this to the attention of the provider who agreed complaints were not routinely handled as they should be.
● People we spoke with told us they had made complaints to the service; however, we found no records of the complaints highlighted to us.

The service failed to record and fully investigate all verbal and written complaints. This was a breach of Regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

At our last inspection we recommended the provider reviewed best practice for recording end of life care preferences. At this inspection we found some improvements had been made. The assessment form prompted the assessor to have a discussion with people about their end of life care wishes.

● The assessment form used by the service, had a space to record people's advanced care wishes. However,

this was not always completed fully.

● The service rarely supported people with end of life care needs. Staff had not received training in end of life care.

● The new office manager told us "If we did take on a package to support someone at the end of their life, we would work with the district nursing team, we would also get the staff trained.

● The service had recently supported a person whose health had rapidly deteriorated. We noted The care plan had been updated to reflect the change in need.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed to keep records relating to care securely. Records were incomplete or inaccurate. Quality assurance processes did not drive improvement. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found ongoing concerns relating to record management and quality assurance processes.

● Following the last inspection, the provider sent us an action plan detailing how they would make improvements. At this inspection we found actions identified by the provider were not completed. Care plan and medicine audits had not been completed regularly. The provider had told us these would be completed every three months. The last medicine audit was completed in December 2018. When audits were completed they did not identify what action was required and who was responsible for completing the required action. A care plan audit completed after our last inspection stated, "MAR charts seen are acceptable", however we found MARs to be incomplete and did not follow NICE guidelines.
● Daily record audits completed did not drive improvement. There was no evidence of the issues identified as being resolved.
● Care records were not routinely kept up to date. One person's care plan stated they had a weekly domestic and shopping call. However, no weekly visit had been scheduled since October 2018. Two people's initial assessment and risk assessments were not readily available on day one. The registered manager sent them to the office for us to review on day two. Care plans did not always reflect what care had been scheduled. For instance, a care worker had been booked for four days and the care plan stated they only had two days of support. It was not clear which record was accurate. The provider told us the person only required two days of support.
● Care plans did not provide adequate guidance for staff on how to support people with their medical conditions. One person's file stated, "Observe for low blood sugar at 4 or below and if signs of lethargy, sweating, drowsiness call GP". However, the staff had not received training on monitoring blood sugars.
● Daily care record written by staff were of a poor quality. People told us "There's no detail about the person in the report it's just repeated sentences around the jobs they have done" and "The statements are very

limited in the book, they don't have a descriptive English."

The provider had not ensured quality assurance processes had the desired effect. We found ongoing concerns about the management of the service. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Providers and registered managers are required to notify us of certain incidents or events which have occurred during, or as a result of, the provision of care and support to people. One notifiable event is when there has been an allegation of abuse. We checked our record against records held at the service, we had not been notified when required.
● We found the service had reported an alleged theft to the police. The service failed to inform us about this. One person had fallen resulting in a fractured hip. The service had failed to inform us about this.

The provider and registered manager failed to notify us of all the events it was legally required to do so. This was a beach of Regulation 18 (Notification of other incidents) of The Care Quality Commission (Registration) Regulations 2009.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● At the beginning of our inspection there was a registered manager in post. It was evident throughout the visits to the office; the registered manager was in conflict with the provider. The registered manager told us they did not have confidence the service had made improvements from our last inspection.
● It was clear from discussion with staff both within the office and care workers the registered manager did not attend the office on a weekly basis. One member of staff told us the registered manager had been in the office twice a month over the last few months. A care worker told us "I don't see [Name of registered manager], they are not regularly in the office."
● We asked the provider to explain what events would trigger the threshold for duty of candour (DOC). They were able to tell us when they would invoke the DOC.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Since our last inspection the provider had developed a service user questionnaire. People told us they had been sent a questionnaire. One person told us "We had a survey around January."
● People told us they did not think the service was well-led. Comments from people included, "A lazy company. There have been some improvements recently, but they have a way to go," "The staff are under a lot of pressure. They are OK, but the hierarchy don't look after them," "The office needs improving and then maybe the other annoying things wouldn't happen," "The manager just says, 'yes' but it doesn't mean anything will happen" and "When you call they are vague and pay lip service to your problem, they just placate people."
● We asked the provider how often staff were offered a team meeting. We did not receive a satisfactory answer. We asked for minutes of meetings. No meeting minutes were provided. Staff told us they did not meet with management on a regularly basis.

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

Continuous learning and improving care; Working in partnership with others

● The service worked with external healthcare professionals and the local authority. Where there had been a change in need the service requested a joint review with the social worker.
● Office staff were able to tell us what discussions they had had with the provider following the return of completed questionnaires. However, the discussion was not recorded.

This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (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 will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The service failed to notify us of all the events it was legally required to do so.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service did not always act in line with the Mental Capacity Act 2005 and its associated Code of Practice.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service did not follow national guidelines when completed medicine administration records. This placed people at risk of not receiving their medicines when required.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The service failed to routinely record and fully investigate complaints. It did not act within the guidance of its own policy on how to handle complaints.

Regulated activity	Regulation

Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The service did not ensure staff were routinely recruited to ensure they had the right skills and attributes to work with people. All the required checks were not always completed.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service did not provide staff with routine support. One to one meetings with a line manager and an annual appraisal of their performance did not happen in line with the provider's expectations. Staff were not deployed to allow them to provide people with the care they required at the times they requested.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service was not managed well. Quality assurance processes were ineffective in driving improvement. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued a Warning Notice.