Vista Home Care Services Limited

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Inspection report

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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

The inspection took place on 15 and 19 October 2018 and was announced. We spoke with staff and people using the service up until 1 November 2018. The service had previously been inspected on 15 August 2016 and rated good. Prior to that inspection the service had been inspected in May 2014 and was not compliant with the management of medicines or the regulation requiring supporting workers.

CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of the inspection they were supporting 27 people although the registered manager was unclear with us as to how many of these people were provided with a regulated activity of 'personal care'.

There was a registered manager who had been registered since 2014. 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.

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Recent staff recruitment had not been robust. Staff employment history had not been explored, and there was only one reference in one candidate's file and this did not match any employer listed on their application form. From the records we reviewed, one person had commenced providing care before their Disclosure and Barring Service check had been returned.

People told us they felt safe whilst staff were providing care. However, we found elements of the service which were not safe. For example, we could not always gain a response to the registered providers telephone line. People's relatives and professionals also reported to us, they had the same issue. This meant it was not possible for people to contact the office for an immediate response. We raised our concerns with the registered manager to ensure they instigated an effective system to ensure people were able to contact the service by telephone.

Rotas we were provided with at inspection were inaccurate as they had the same care worker listed to visit people at the same time. People had told us on a few occasions, calls had been missed which might have been as a result of the way the rotas were designed. We advised the registered manager or these concerns, as they were unaware any calls had been missed.

Risk assessments were not in place for all identified risks such as to manage the risk of falls. Risk reduction plans to mitigate all identified risks needed to contain all the information required to guide staff. Most people at the service had low level needs, however, it was important to ensure all risks were recorded and reduced.

The service mostly reminded people to take their medicines by way of a prompt. However, the recording of

the administration of medicines was not in line with current best practice. We also found not all staff had their training to administer medicines refreshed or their competency checked by a person assessed as competent to do so. The registered manager agreed to rectify this immediately and had put a system in place shortly after the inspection had finished.

We found training for staff was not all up to date, although some had been undertaken following the announcement of the inspection. Supervision and appraisal records did not follow nationally recognised best practice in terms of quality. The registered manager had not kept up to date with nationally recognised best practice guidance in the provision of community based domiciliary care services.

The majority of people supported had the capacity to consent to their care and treatment. However, the registered manager and staff did not have a good understanding about the Mental Capacity Act 2005. The registered manager had not understood, they needed to formally assess people's capacity when a person's ability to consent declined or fluctuated.

Relatives and people using the service told us staff were very kind and caring, and people were treated with dignity and respect. Our conversations with staff confirmed they were caring and were passionate about providing care that was centred around the individual and to their preferences. They could describe to us how people liked their care to be provided. However, people and their relatives told us about missed calls, which meant the care they were expecting was not always provided.

The registered manager did not have an effective system in place to ensure personal information was stored confidentially. They did not understand their responsibilities to do so under data protection legislation.

The registered manager told us there had been no complaints. However, during our discussions with people using the service and their relatives, they highlighted areas of care they considered could be improved and told us they had reported these to the registered manager. The registered manager had not recognised these concerns as an opportunity to learn and drive continuous improvements.

There was a lack of systems and processes, including regular audits which meant the registered provider was unable to identify where quality and safety needed to improve. Up to date nationally recognised guidance had not been implemented by the registered manager, although policies had been updated by their policy provider to reflect best practice. The registered manager had failed to notify CQC about significant events, which they are required to do so by law.

We found several breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

We identified concerns around the recording of medicines administered by care staff.

Risk assessments did not always identify all the risks to people using the service and were not completed well.

Recent recruitment practices were not robust.

There was no system in place to ensure the company phone line was manned in case of emergencies.

Is the service effective?

Requires Improvement

The service was not always effective

Most people were able to consent to their care and treatment. However, the registered provider was unaware of their responsibility to ensure they undertook mental capacity assessments if a person did not have the capacity to consent.

Not all staff supervision and appraisals were up to date or were of good quality.

Staff supported people without the necessary training.

Is the service caring?

Requires Improvement

The service was not always caring.

Information was not held securely and in a way that met data protection requirements.

People's relatives told us the care staff were kind and caring.

Relatives told us the way care and support were provided respected their relations' privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive

People's care plans did not always fully reflect their physical, emotional and social needs. Some care plans needed updating to reflect people's current care needs.

The registered manager had not recorded any complaints although people told us they had informed the registered manager of their concerns.

Information was not provided to people in accessible formats.

Is the service well-led?

Inadequate

The service was not well-led.

There had been inadequate management of this service.

There was a lack of robust and regular audits or systems to demonstrate the registered provider was assessing the quality of their service.

The views of people using the service and their relatives had not been formally sought to enable the service to use this information to improve their management processes

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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 prompted in part by concerns which had been raised to us in relation to the management of the service.

This inspection took place on 15 and 19 October 2018 and was announced. We gave the service notice of the inspection visit because it is small, and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in. We visited the office location on 15 and 19 October 2018 to see the manager and office staff; and to review care records and policies and procedures. We also spoke with staff, and people using the service up to 1 November 2018.

The provider had not been asked to complete a Provider Information Return as part of the Provider Information Collection. 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 reviewed all the information we held about the service and liaised with stakeholders. These included Healthwatch, the local authority safeguarding, West Yorkshire Police and the local authority commissioning teams.

We spoke with five relatives and one person who used the service. We also spoke with the registered manager, the aspiring manager (one of the senior care workers who was training to be a manager), and four care staff. We reviewed five care plans for people using the service. We looked at the registered providers policies and procedures, training and development records and records in relation to the management of the service. We also reviewed three staff files and all staff training records.

Requires Improvement

Is the service safe?

Our findings

We found the service was not always safe as the assessment and management of risk including the safe management of medicines demonstrated a breach in Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Three of the relatives and one person using the service told us the service provided by the agency had not always been reliable. They spoke highly of individual staff and told us they felt confident their relative was safe, whilst staff were providing care. However, they reported some calls had been missed, and on occasion some staff had not stayed the allotted time frame. They also reported difficulty getting a response to their phone calls to the agency. We also had difficulty getting a response to the phone number listed for the agency and we found the office was not staffed at times during our inspection and the registered manager unavailable. This raised concerns in relation to accessibility in emergency situations and we found no effective system in place for this so that people could know they would receive an effective response should these situations arise.

We checked records to see how medicines were managed for those people who needed such support. The registered provider had a comprehensive and detailed policy and procedure for managing medicines which referenced best practice from the National Institute for Health and Care Excellence (NICE) and current legislation. However, the registered provider was not following their policy and we found the service was not managing medicines in line with up to date evidence-based practice. For example, one person was supporting people with their medicines and they had not been trained or had their competency checked. Other staff had not had their competency checked in line with best practice.

We found a complete and contemporaneous record for each person's medicine had not always been kept. Staff were mostly checking people had taken their medicines and prompting people to take their medicines, often in conjunction with family members. This meant it was important safe recording systems were in place. We found from reviewing Medication Administration Records (MARs), care workers were not recording the medicine support given to a person for each individual medicine on every occasion. Some MARs had been provided by the pharmacist and these did contain a line for each medicine, but the ones provided by the registered provider did not, which meant staff were signing without a record of what medicine they had administered.

Records indicated staff were applying creams to two people but there were no body maps or details of the cream recorded. We raised this with the registered manager at the inspection, who agreed to investigate this.

We checked how risks to people were assessed and their safety monitored and managed so people were supported to stay safe. The registered provider utilised an environmental risk assessment to ensure staff were protected from an unsafe environment. We checked other risk assessments and risk reduction plans and found these had not always been completed. For example, one person identified at high risk of falls did not have falls risk assessment and risk reduction plan in place. Another person was at risk of developing

pressure ulcers but again a detailed risk reduction plan was not in place. This meant the registered provider could not evidence they had identified and reduced the risk to people using the service.

We asked the registered manager if they supported people who required assistance to be moved safely. They told us there was no one requiring this support. In addition, staff had not received practical moving and handling training. However, our review of care records found one person needed assistive equipment to move. There was no record of when this equipment had been checked to ensure it was safe to use, or contingency arrangements if the equipment broke down. Detailed guidance for staff to move this person was not provided in the moving and handling care plan. The registered provider agreed to action this immediately she was made aware of the requirement.

We asked to see the records and analysis of accidents and incidents to see how the service learnt lessons when situations did not go to plan. The registered manager told us there had been no accidents and incidents since the last inspection; therefore, there were no records to analyse. However, our review of daily notes found one person's medicine had been dropped and had therefore not been administered but there was no record indicating what had been done about it once the staff member reported it to the office, and the office had no record of this incident. We therefore, could not be confident the lack of records was due to a lack of incidents or a lack of recording.

Recent recruitment practices had not been sufficiently robust, although there had been limited recruitments as most staff had been working at the service for years. The registered provider had a comprehensive recruitment policy in place which provided the service with a step by step recruitment process. This required two satisfactory written employer references including one from the last employer. One member of staff whose recruitment file we looked at only had one reference on file, and this referee was not listed as a past employer on their application form and the reference was only taken verbally over the telephone. Disclosure and Barring Service (DBS) checks had been completed although one record was returned one month after the member of staff had commenced in work. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

We found no system in place to monitor the call times and the registered provider did not operate an electronic system. Staff recorded in the daily records the time they entered and left a property and we were told these were checked when they were returned to the office at the end of each month. One of the senior care workers who was training to be a manager (aspiring manager) completed the weekly rotas. A review of the rotas showed some staff were on the rota to be supporting people at the same time. In some cases, there was not time between visits to enable the care staff to travel between visits as care had been timed without any gap. We were concerned about how the rotas were worked out.The aspiring manager told us they thought there was enough time between visits as the calls were all within the same area. However, relatives had discussed missed calls and short calls with us which confirmed there was a lack of oversight to ensure there were enough staff to cover the required calls and that the rotas were reflective of the care provided.

Staff told us they thought the care they provided was safe. One said, "When we go in we make sure the environment is safe." One said if they could not gain access to the property they would contact the registered manager, so they could ring the person, as they were not given people's telephone numbers to call. Staff could describe the types of abuse they might find in the community setting and told us they would report any concerns to their manager.

Requires Improvement

Is the service effective?

Our findings

The service was not always effective. We looked at the records in relation to induction, training, supervision and appraisal to check how the registered provider was supporting staff to develop. We also checked whether the registered provider utilised current legislation, standards and evidence-based guidance to ensure they worked to current best practice. We found the registered manager had not kept up to date with evidence-based practice to ensure staff were working to this. This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they were using the Care Certificate for staff who were new to care on commencement at the service. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers. We saw evidence some workbooks had been completed and signed off by the aspiring manager and existing staff had also completed sections of the Care Certificate. The aspiring manager was unaware the workbooks they were signing off were part of the Care Certificate. The registered manager agreed to look again at the Care Certificate to ensure this was completed in line with best practice.

Nationally recognised best practice recommends care workers receive supervision in a timely, accessible and flexible way, at least every three months with an agreed written record of supervision given to the worker. In addition, the recommendation is for care workers' practice to observed regularly, at least every three months, their strengths and development needs are identified; and performance is appraised regularly and at least annually. The registered manager was unable to provide us with a supervision matrix to confirm all staff had received supervision and appraisal in line with best practice. They told us this information was held in each member staff record. We checked three records. One person had their annual appraisal and supervision on the same day. One record stated this had been completed over the telephone and another record face to face in the office. Neither had been signed by the supervisee. This person's records showed supervision was taking place at the required frequency but from the records we reviewed it was clear that it wasn't being used as an accountable process which supports, assures and develops the knowledge skills and values of the care worker. Another care file we looked at for a new care worker did not have any record of supervision or competency checks. We confirmed with this staff member they had not had supervision since they started work.

Staff require their performance to be appraised yearly to ensure they develop in their roles. The registered manager told us performance appraisals were up to date, but we were not provided with the evidence to confirm this. We saw one record of performance appraisal in a staff file, but it showed there had not been a review of the staff members learning and development needs nor feedback from people who used the service.

The registered manager had completed Vocationally Recognised Qualifications (VRQs) to level 5. One of the care staff who aspired to be the manager had commenced a level 5 VRQ. This is the expected level of qualification for a registered manager. We were not provided with a matrix to confirm staff had been trained and had their training refreshed. We were provided with a computer print off for each member of care staff

which detailed when they had been trained and this showed not all training was up to date and some had been completed after the inspection had been announced. All the training was provided online with each staff member awarded a pass rate. Care staff had not received practical moving and handling training to accompany online training and we were told by the registered manager the agency was not supporting anyone who required assistance to move. However, we identified one person was helped to move with assistive equipment. We asked the aspiring manager who had trained staff how to use this equipment and they confirmed this was the registered manager. We raised our concerns with the registered manager following the inspection as we could not see the evidence to confirm the registered manager had the knowledge or skills to train staff to move people safely.

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. We checked whether the service was working within the principles of the MCA.

The majority of people supported by the registered provider had the capacity to consent to their care and treatment. However, the registered manager and staff did not have a good understanding about the Mental Capacity Act 2005. The registered manager had not understood, they needed to formally assess people's capacity when a person's ability to consent declined or fluctuated. The registered manager told us there were only two people at the service who lacked capacity to consent to their care and treatment and the arrangements for the service had been made through their family. When we asked the registered manager about the assessment of mental capacity they told us they had never completed a two-stage capacity assessment. They could not locate the paperwork for this assessment for us but were certain, their policy provider had provided the paperwork. They were able to tell us, "always assume people have capacity". However, they couldn't tell us how they would determine if people's mental capacity was an issue. The aspiring manager who assessed people prior to taking up the service confirmed they had no training on how to conduct an assessment of a person's capacity. Neither the registered manager or the aspiring manager could describe to us the process they might follow to determine how to act in a person's best interests. They told us if they were concerned about a person's mental capacity, they would go back to the social worker and said, "They always take the lead." The registered manager agreed to address the issue immediately and confirmed with us following the inspection, they had located the relevant paperwork and had undertaken additional research to improve their knowledge.

We asked specifically about Lasting Power of Attorney (LPA). A health and welfare LPA enables a person to give another person the right to make decisions about their care and welfare. A finance and property LPA enables a person to appoint an attorney to decide on financial and property matters. They were able to tell us what this meant, the different types of powers and how this could be used to support people. They told us they did not routinely ask people whether they had a LPA.

We saw signed consent to care forms as evidence people had consented to their assessment and sharing of their personal information at the service commencement stage, but we saw no recorded evidence to confirm people had consented to their care arrangements after this initial stage. However, our discussions with staff confirmed, they sought consent from people at each visit. We raised our concerns with the registered manager and they agreed to ensure recorded consent to share information was regularly reviewed with people they supported.

We were aware some people had received support from community professionals, but the outcome of their interventions had not always been recorded. The registered manager could tell us about one person who

had been assessed by the continence service, advocacy, and sensory impairment team but there was no record of the outcomes of these conversations in the person's file to ensure staff knew how to support people with changing needs. The registered manager agreed to rectify this and ensure documentation included professional advice.

Requires Improvement

Is the service caring?

Our findings

Relatives and people using the service told us care staff were kind and compassionate. One said, "I think they are very caring. Some are extra." Another relative told us some care staff sit with their relative to chat if they finished their tasks early. All the care staff we spoke with came across as very caring people, who were passionate about providing a kind and caring service.

Most relatives told us their relation was cared for by a consistent staff team, although one reported their relative was not provided with consistency of individual staff. Another said their relative was provided with a male carer which was not discussed with them prior to the call and was a concern to them.

People's relatives told us as far as they were aware care workers promoted people's privacy and dignity and were respectful towards them, including how they addressed them. Staff we spoke with demonstrated how they provided care that supported privacy and dignity. For example, one member of staff said, "I make sure curtains are closed, door shut, I ask her, tell her what I'm doing."

Staff described how they provided person-centred care, including meeting individual needs and promoting independence. For example, one member of staff said, "You have to promote their independence. For example, when getting washed I encourage them and say, 'Why don't you wash yourself.'" The service had an equality and diversity policy in place. Equality and diversity training was provided online, and most staff had completed this. Our discussions with staff confirmed they would respect peoples protected characteristics in line with the equality legislation and ensure they treated people as individuals.

Information in people's care plans on how to best communicate was not well recorded. However, when we asked staff how they learnt to communicate with people, they said they had been out with the registered manager the first time, who had given them some pointers to support the person.

During our inspection we were aware the registered provider used members of staff own personal mobiles to disseminate confidential information. We saw no evidence in relation to a policy on this. We were concerned about how confidential information was handled as one person's daily records were missing, and the registered manager had been the last person to handle these records. They retraced their steps whilst we were at the inspection but could not find the records and more worryingly told us they might have left them in another person's home. The lack of processes to protect people's personal information breached Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records we reviewed did not show people or their representative had been involved in developing and reviewing their care plans. There was a section on the care plans "Service User/Advocate to sign", but this had not been completed in any of the care plans we looked at. People had not signed their care plans, although they had signed the consent to share information. However, all the relatives we spoke with told us they had been involved with their relative at the commencement of the service which they were funding themselves or through a direct payment, so the care plan had been designed around the care their relation was requiring.

We asked the registered manager the arrangements for advocacy services in the local area, if this was required and they told us this was accessed through the local authority Gateway to Care.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive. We found the registered provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a lack of complete, and up to date care records and those records which were held were not held securely. We were concerned about how the service stored people's records as these were not all available to us during the inspection. For example, we asked to see the daily records completed by care workers following their provision of care. We were told these had been scanned onto a USB (electronic storage device) which was not held at the office but at the aspiring manager's home. There were a few records from September in the office and one from July in a person's file. We were told daily records were shredded after they were scanned. The aspiring manager told us the USB was not password protected and this was of significant concern in relation to the safe storage of confidential information.

The registered manager told us they or the aspiring manager assessed people prior to the agreement to provide care. Recommendations came through the local authority for those people not eligible for funded social care and for those people who received a direct payment. If the person was funded through a direct payment, they were provided with a person led assessment providing detail about the person and the care required. If people arranged care privately, the care staff obtained key information from discussions with the person and their family.

We looked at six care records during this inspection. Care plans contained minimal information about people's life history, such as people's family life, employment and hobbies. This information enables staff to understand the person so that they can provide personalised care and engage in meaningful conversations that promote social interaction.

We found that one person had recently been discharged from hospital but there were no records that their needs remained the same or had in fact changed. A further person had a large increase in their care package following hospital admittance but there was no evidence of a reassessment of their needs to indicate why this was required.

The Accessible Information Standard requires a registered provider to ask, record, flag and share information about people's communication needs. This aims to ensure people with disabilities, impairments or sensory loss are provided with information they can understand, plus any communication support they need when receiving healthcare services. We could see one person had a visual impairment and were told they required assistance with their post and finances due to this. The information provided to them was not in large print and they had signed to consent to information sharing, although there was no record to confirm this has been read to them or they knew what they were signing.

As part of the inspection we reviewed how the service responded to complaints to see how concerns and complaints were used as an opportunity to learn and drive continuous improvement. The registered manager told us there had been no complaints at the service. Relatives we spoke with told us they had not made formal complaints, but several had contacted the agency with concerns about the service. This

included how one staff member was supporting their relative and their level of skill, missed calls, communication, and staff not staying the duration of the call. Relatives told us they had spoken with the registered manager about these issues and they felt their concerns had been listened to, although not always resolved. This demonstrated a failure in their systems and processes, and the recognition of the importance of receiving and acting upon complaints. This demonstrated a breach in Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

We found the service was not well-led. The lack of leadership and management at the service including robust quality checks demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of this inspection we looked at records in relation to the management of the service such as audits, policies and procedures and information provided to people using the service. We found there were no systematic audits undertaken by the registered manager to identify where improvements were required. There was no monitoring of call times. There were issues with how staff rotas were compiled as the same member of staff was on the rota at the same time for two different people using the service, and there was insufficient time planned between some service users to enable the staff to travel to the call. Recruitment practices were not robust. Staff were not receiving effective supervision. Staff training was not up to date and there were no systems in place to evidence the registered manager was testing staff knowledge following e-learning. Furthermore, the registered manager had not ensured all staff had been trained and were competent in the management of medicines and in the practice of moving people safely. Issues we found concerning the storage and processing of personal information meant that the Registered Manager had not ensured this was in line with the requirements of the General Data Protection Regulation (GDPR). The registered manager had also both, failed to ensure peoples care records were up to date and contemporaneous and to recognise and deal with concerns raised by people's relatives.

The registered manager did not recognise their responsibility to record complaints. Relatives told us they had raised concerns with the registered manager about missed calls, lack of communication, and the duration of calls. We found no reference to these concerns to show how the registered manager had used this information to drive improvements. They told us there had been no complaints or concerns raised about how the agency was functioning.

The home utilised a suite of policies and procedures which they had purchased from an external policy provider. These were comprehensive and referenced up to date legislation and best practice. The registered manager however, had not applied them to her service and was not following the detailed processes within them.

As part of our inspection we check to see how the views of people using the service are obtained and how this information is used to drive improvements. We weren't provided with evidence to confirm people's views of the service had been obtained. The aspiring manager told us they thought questionnaires had not been sent out this year as they "usually got asked to help fill them in" by people using the service. Relatives confirmed to us they had not completed any recent questionnaires in relation to the quality of the service. They told us the reliability of the agency had taken a downward turn since the summer of 2018. Feedback from people using the service and their relatives would have highlighted the issues to enable the registered manager to put in measures to improve the quality of the service they were providing.

The registered manager told us by email that team meetings were held regularly at the service although we

were not provided with the minutes. Staff confirmed to us team meetings were not taking place. Team meetings are a good way for staff to share their views on how improvements to the service can be made and to share good practice.

The registered manager was aware of their responsibility to notify CQC of certain events, such as a change of address. They had not met this requirement and had changed their email address without notifying us. Although they said this was recent, we saw evidence to confirm this had been at least three months prior to our inspection.

The registered provider is required to display their CQC rating 'conspicuously' and 'legibly' at their main office and on their website. They were on display at their office. The registered provider did not have a website.

Staff spoke highly of the registered manager and the support they provided to staff. One said, "She takes really good care of us and service users." They talked about the teamwork amongst staff and how they worked together to ensure any gaps through sickness were covered. They told us what was good about the service was the teamwork. They reported good communication through group texts to ensure information about people using the service was communicated with each other. However, communication through staff's own mobile devices, needed additional safeguards to ensure it met the requirements of the Information Commissioners Office (ICO) and we have directed the registered provider to the ICO website.

The lack of leadership and management at the service meant that the service had failed to meet the fundamental standards below which care must never fall. The service had not continuously improved in line with current best practice to ensure people were provided with a safe, effective, caring and responsive care.

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 12 HSCA RA Regulations 2014 Safe care and treatment The assessment and recording of risk was not robust to ensure risks of harm were minimised. Medicines management was not in line with best practice. The system for managing and monitoring missed calls was not in place, and when calls were missed, there was no one to call to find out where staff were.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not recognised or acted upon to ensure the service continuously improved.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service had no effective management systems in place. They were not working to current best practice and the registered manager had not kept up to date with the requirements of this type of service or those of the registered manager.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The system for supervising staff was haphazard and the quality of supervision did not evidence it was used to develop the knowledge and skills

of staff.
Training was not up to date and there had been no management analysis of the training needs of staff.
A review of performance had not been undertaken in line with best practice.