Caring Hands Cheshire Ltd

Caring Hands Cheshire Ltd

Inspection report

45 A 1st and 2nd Floor
Church Street
Runcorn
Cheshire
WA7 1LX

Date of inspection visit:
22 January 2018
23 January 2018
24 January 2018

Date of publication:
18 May 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 22, 23 and 24 January 2018 and was announced.

At the last inspection on 3 May 16 we found breaches of the regulations, including Regulation 9 Person centred care, Regulation 12 Safe care and treatment and Regulation 17 Good governance. The service was rated requires improvements overall.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve person centred care, safe care and treatment and governance to at least good.

This small domiciliary care agency was providing personal care to people living in their own homes in the community. It provided a service to older adults and people with a learning disability. The number of people receiving a service had reduced from 19 to 10 people since our last inspection. There was a registered manager in post at the time of the inspection who explained the provider was reducing the number of service users within the service in preparation for moving to another premises/area.

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.

During this inspection we found continued breaches of the regulations. Risks were not always being identified or mitigated for people using the service, there was minimal information about people seen in their care plans and quality assurance systems were not robust. You can see what action we told the provider to take at the back of the full version of the report.

On our last inspection we found there was not enough person centred information about people receiving a service. We found on this inspection people living with dementia had no person centred care plan and only one person out of 10 had an "All About Me" care plan in place. An "All About Me" care plan is written to provide important information about the person. The provider had not met their legal responsibility and remained in breach of regulation; person centred care.

We found on this inspection the registered manager had conducted a survey but had not undertaken any other audits of their systems. For example, there had been no audits of medication administration records and we had not been provided with a statutory notification when appropriate. The provider had not met the legal requirements and remained in breach of regulation, Good Governance.

On our last inspection medicine management systems were not safe. Medication administration record sheets (MARS) were checked in people's homes who we visited. Two out of the four people we visited in their own homes were being supported with their prescribed medicines. Both people's MARS had gaps or a symbol X with no code to denote what this was referring to. We found other risks were not being identified or mitigated for people receiving the service. For example, emergency contingency plans were not clearly written in care plans for people. The provider had not met actions from the last inspection and remained in breach of safe care and treatment.

Mandatory training (which is essential training) being offered for staff was minimal and only included moving and handling training provided by the registered manager who was an approved trainer.

Staff had undertaken medicines awareness as part of the Care Certificate but had not completed a specific training course in safe medicine management. Staff competency checks were not seen in staff files so we could not be sure staff had been assessed as competent.

We were concerned there were not enough staff trained with the necessary skills to provide a good standard of care for people.

Care plans contained a bullet pointed list of tasks people needed support with in the morning, lunch, tea and evening with no specific times documented for people to check when they could expect to receive their care. We viewed detailed moving and handling risk/environment assessments but we found specific risk assessments relating to peoples' health were missing.

Peoples respect and dignity were not always being upheld. We received some information of concern on this inspection related to how people and their relatives were not always treated with respect.

Staff we spoke with were not knowledgeable in safeguarding. We found there was a system in place to record and report safeguarding concerns but the registered manager told us there had been no safeguarding referrals made since the previous inspection in May 2016. The Safeguarding Authority confirmed they had received a safeguarding concern and they were looking into this.

The complaints process and system was not robust enough. There was a complaints log seen.

We checked recruitment practices within the service and found that appropriate checks were being undertaken to reduce the risks for people receiving care.

Supervisions and appraisals were seen recorded in staff files.

Staff had received an induction including the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It's made up of the 15 minimum standards that should be covered for all staff 'new to care' and should form part of a robust induction programme. All staff had completed the Care Certificate.

We received positive comments about some of the care staff and the registered manager.

There was a system of recording accidents and incidents. There were none logged at the time of the inspection.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks were not always being identified or assessed for staff to know how to mitigate the risks.

Medicines were not being managed safely with medication administration sheets not always being completed.

Safeguarding procedures were not robust enough. Staff were not knowledgeable enough about different types of abuse to be able to identify abuse.

Recruitment practices in the staff files we viewed included the appropriate checks.

Is the service effective?

Inadequate

The service was not effective.

Principles of the Mental Capacity Act 2005 were not being followed with specific consent not always being documented in line with the legislation.

Training offered to staff by the provider was inadequate. Staff we spoke with had limited knowledge in safeguarding and Mental Capacity Act 2005.

People were receiving support to maintain their nutrition and hydration but this was not being monitored effectively.

Healthcare professionals were being involved in people's care.

Is the service caring?

Requires Improvement

The service was not always caring.

We received mixed reports about how staff upheld peoples dignity and demonstrated respect.

The registered manager had obtained some peoples views about

the service. People were not always being encouraged to make decisions about their care.

Advocacy services and equality and diversity policies had been implemented in the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The registered manager had a system of reviewing care plans.

There was limited information about people's preferences, likes and dislikes for staff to know how to provide person centred care.

There was a complaints system and log however, details of the complaint were not always recorded with no letter of response to the complainant.

Is the service well-led?

Inadequate

The service was not well-led.

The risks identified on this inspection had not been identified through the service's own quality assurance checks or audits.

There were no medication audits taking place despite this being a concern on the previous inspection on 3 May 2016.

The registered manager failed to notify the Commission which is a legal requirement.

Positive feedback was obtained about the registered manager.

Caring Hands Cheshire Ltd

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 checked 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.

Concerns about the standard of care were brought to our attention prior to this inspection. The Local Authority were made aware of these concerns.

This inspection was announced and took place on 22, 23 and 24 January 2018.

We gave the service 48 hours' notice of the inspection visit because it was a small service and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in. The inspection was undertaken by one adult social care inspector.

We reviewed all the information we held about the service and also gathered information from the Local Authority.

We reviewed care records for six people receiving a service including associated records such as medication administration sheets and daily records. We visited four people in their own homes who were receiving a service, spoke with three staff including the registered manager and spoke with five relatives.

Inadequate

Our findings

People who were able to converse with us told us they felt safe with the staff who were delivering care. Not all relatives we spoke with had confidence in the staff to provide a safe level of care. Two relatives out of five we spoke with raised concerns about the safety of the service. One relative told us they did not consider their relative was safe and they had to "keep a close eye" in view of safety concerns such as keys being left in the person's door by care staff upon leaving the property, leaving the person who was bedbound vulnerable to anyone walking in. Other people we spoke with said "They're absolutely fantastic I don't know what we'd do without them". Another person said "yes" in response to us asking them if they felt safe.

On the last inspection on 3 May 2016 the provider was in breach of Regulation 12 Safe Care and Treatment due to unsafe management of medicines. On this inspection we found there was a continued breach of this regulation because medication administration sheets had not always been completed or completed accurately.

There was a breach of safe management of medicines on the last inspection. Since then there were improvements as the provider had implemented a medicines administration record (MARS) for staff to record when people were supported to have their prescribed medicines. However, not all prescribed medicines were listed on the MARS sheet with dosages, start and end dates of each prescribed medicine/cream. We checked all four people's MARS sheets when we visited them at home and found gaps where staff had not signed to confirm if their prescribed medicines including prescribed creams had been administered or not. This meant we could not be sure people had been offered their prescribed medicines and creams. One person who was bedbound had a prescribed cream for their pressure area. We found there were gaps on the MARS sheet. We asked the person if the staff asked them if they wanted to have their prescribed cream. The person told us they frequently declined. This had not been documented in the care records or on the MARS sheet. In the event people decline their prescribed creams or medicines it can lead to pressure areas developing or other secondary problems. It is imperative care staff keep accurate records whether people are offered and have received their prescribed medicines and creams to evidence they have received their course of treatment. Poor completion of medicine records illustrated the provider had not done all that was reasonably practicable to keep the person safe from harm. Staff were using a code X in some cases with no explanation what this meant. The systems in place for supporting people with their prescribed medicines were not robust enough and in addition to this we found staff had not received training in supporting people with their prescribed medicines further increasing the risk of harm.

This was a breach of Regulation 12 (2) (g) Safe Care and Treatment of the Health and Social Care Act

Regulations 2008 (Regulated Activities) 2014

We also looked at care plans and found that they contained a bullet pointed list of tasks people needed support with in the morning, lunch, tea and evening with no specific times documented for people to check when they could expect to receive their care. Times of care visits are important to ensure people receive care when they need it in accordance with when they need their prescribed medicines and pressure relief. We viewed detailed moving and handling risk/environment assessments but we found specific risk assessments related to people's health were missing. For example, people who were receiving catheter care had no catheter care plan/risk assessment for staff to know what the risks were and how to mitigate those risks. The care plan specified care staff were required to undertake tasks such as empty the catheter bag. There were no risk assessments or care plans in place for staff to know what to do. For example, we found no information for staff for how to identify a blocked catheter or what to do if that happened. This information is important for staff to know how to safely care for a person requiring catheter care.

We looked into how risks were being identified and assessed and found not all risks had been managed safely. We viewed one person's assessment documentation which detailed a specific health condition which required staff to be aware of in order to manage the risks associated with the health conditions. We found a body map detailing bruising to the person which the records stated needing monitoring. We did not find any records to demonstrate the bruises/marks had been monitored. The registered manager told us the body map was completed when the registered manager first met the person when undertaking an initial assessment. There were no records to illustrate over what time frame the cuts and bruises had healed. The registered manager was made aware of this and we ensured they had put a care plan in place setting out for staff what the risks were and what they needed to do by the end of our inspection. In the event staff are unaware of the risks associated with people's specific health conditions they are unable to identify signs which may require medical attention. This means the provider had not ensured staff had all the information they needed to care for people safely.

Other risks had not been identified such as how staff were to support people to evacuate their home in the event of an emergency. Two people we visited in their own homes were nursed in bed and required a hoist to assist them to transfer out of bed. There were no emergency contact details in the event the hoist failed or a risk assessment as to what steps to follow to safely transport the person out of their property. This meant that in the event of an emergency staff would not have information to follow to know the safest method of evacuating the person from their home to keep them safe. In the event there was a mechanical breakdown of a vital piece of equipment such as a hoist for someone to be supported to move position, staff need an emergency contact number. The registered manager acknowledged this and confirmed they would visit each person and agree the emergency contingency plan appropriate to their needs following the inspection.

We viewed one person's daily logs sheets who was living with dementia receiving four calls per day, the evening/bedtime call on the rota was 8pm/8.30pm and the morning call was 9.30am which meant the person who had skin integrity concerns was in bed in the same position for over 12 hours. Despite the registered manager being aware they had a small ulcer which had recently been identified by District Nurses, the person's morning call was later than stipulated on the rota and was at 11.15am. This meant the person was in bed for over 14 hours despite the registered manager being aware they had recently been confirmed to have a pressure sore. This placed the person at further risk of harm of pressure areas developing or worsening. This meant the systems in place were not robust enough and the provider had not done all they could do to ensure people were being kept safe from harm.

This was a further Breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act

Regulations 2008 (Regulated Activities) 2014.

We received further concerns from the Safeguarding Authority about pressure care for another person. There was a safeguarding policy in place and a safeguarding procedure. There were no safeguarding concerns or referrals logged at the office. We checked with the Local Authority and found there was a concern raised by the Local Authority with the provider at the time of the inspection. This was not logged as a concern by the registered manager. Concerns were expressed that a person had developed a Grade 3 pressure ulcer to their right hip. It was alleged this has been caused by inadequate pressure care by care workers from Caring Hands Limited. It was reported care workers had not been assisting the person into an armchair using a hoist as agreed. Consequently the person remained bedbound and the care workers had not been repositioning the person. Family members reported to the Safeguarding Authority some care workers refused to assist with hoisting due to an injury and expected family members to assist with hoisting. The Safeguarding Authority had requested information from the provider on more than one occasion in relation to the safeguarding concern but the provider did not respond and provide the information. The Commission received confirmation from the Safeguarding Authority following the inspection that the safeguarding had been substantiated. The registered manager confirmed they had not completed a body map when the care package commenced and also could not confirm the date when the care package began. We were therefore concerned Caring Hands Cheshire had not done all that was reasonable to protect the person from harm or followed robust safeguarding procedures to protect the person from harm/neglect.

Care staff we spoke with had difficulty explaining the different types of abuse. One staff member said "bruising to body" as the only type of abuse they could think of. When asked who they would report it to they said "higher up and the family". Another staff member said "if someone refuses something and you force them" as the only type abuse they could think of. We found there were no recorded competency checks seen being undertaken including within Safeguarding to check if staff understood their safeguarding responsibilities. Staff were aware of whistle blowing but they did not always know what to do if they had a safeguarding concern. Staff must know the different types of abuse to identify abuse. They must also know what to do when they identify abusive practices.

This was a Breach of Regulation 13 (2) and (3) Safeguarding Service Users from Abuse and Improper Treatment

We checked the recruitment practices within the service and found appropriate checks including Disclosure Barring Service checks and references had been obtained prior to the staff member working with people to deliver care. The Disclosure and Barring Service is a service where checks are undertaken to ensure employers are aware if a staff member has any previous convictions.

The registered manager, the provider and nominated individual were included in the numbers of staff who were on the rotas delivering care. We viewed the rotas and requested more detailed rotas to enable us to see which staff member was due to undertake each care visit. The more detailed rotas we viewed evidenced specific times and the name of the staff member to undertake each care visit. There were mixed views from people we spoke with about whether the staffing was sufficient to meet people's needs. Some people told us they had consistent carers who were on time. Other people told us they were concerned staff weren't remaining in the property for the duration of the care call and the times of calls were inconsistent. The registered manager told us they provided people with "approximate times" when they could expect to receive their care. We found this made it difficult for people and their relatives to always know whether staff were on time or not for them to monitor the service they were receiving.

There were concerns raised at the time of the inspection regarding telephone calls to the office not being received or responded to. The registered manager confirmed there had been an issue with the broadband internet connection to the premises which may have explained this. We found there was an emergency on call mobile for people to contact. There were mixed views regarding how quickly the messages left at the office were being responded to.

Inadequate

Our findings

We looked into whether staff were skilled and knowledgeable in their roles.

Staff had received an induction including the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It's made up of the 15 minimum standards that should be covered if you are 'new to care' and should form part of a robust induction programme. We found all staff had completed the Care Certificate.

Mandatory training (training which has to be completed) being offered for staff only included moving and handling training provided by the registered manager who was an approved trainer. We found no other training was offered to staff by the provider including administration of medicines. As staff were supporting people with their prescribed medicines staff were required to have completed training. We were told by the registered manager staff had completed training in administering prescribed medicines. We requested proof of this by way of certificates to evidence staff had completed training in administering medicines. We received certificates following our inspection which were not dated and were found to be evidence of staff completing the Care Certificate standards for medicine management and not specific training in administering medicines. The Care Certificate does not include actual training in medicines management but provides some guidance as to the standards expected. Therefore staff were administering medicines without having undertaken specific training in administering medicines.

We found the provider had also not offered staff training in Safeguarding people from abuse or Mental Capacity Act 2005 legislation. Staff we spoke with during the inspection were not knowledgeable in Safeguarding or Mental Capacity Act 2005. There were also no competency checks available to demonstrate that staff skills and knowledge had been assessed. The registered manager told us they had undertaken shadow shifts with staff to check their competencies but they had not documented what was checked or what the outcome of these were. We therefore, found the training offered to staff was inadequate.

This is a Breach of Regulation 18 Staff training of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in domiciliary care agencies are called the Deprivation of Liberty Safeguards (DoLS) through the Court of Protection.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found there was no system of documenting consent by people using the service. This meant there was no contemporaneous record of when people had consented to changes to their plan of care or specific consent such as for support with their prescribed medicines. People who had impaired mental capacity who were living with dementia had no lawful consent by way of specific mental capacity assessments or best interest processes in their care records. Two people we visited who were living with dementia had no lawful consent or best interests process seen in their care records. The decisions to accept both care package was completed by the Local Authority or Commissioner prior to the care package commencing. However, there were no decision specific mental capacity assessments/information in care plans written by the registered manager. The care plans did not evidence how the registered manager or provider had considered which decisions they could make (if any) and which more complex decisions they needed support to make by way of a best interests process. The impact of this was people were not always being supported to make their own choices/decisions by way of lawful practices to obtain lawful consent. The registered manager was aware when there was a Power of Attorney in place however there were no specific mental capacity or best interests assessments for obtaining lawful consent. This meant the provider was not demonstrating they were following the legal requirements of the Mental Capacity Act 2005 legislation.

This is a Breach of Regulation 11 Consent of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014

We found care needs were not always being fully assessed. For example, people who were living with dementia had no person centred assessment to include habitual routines with the time they usually would retire to bed and wake in the morning. Choices were not being recorded by staff within the care records for us to see staff were supporting people to make their own choices. Another person with a specific condition had not had their care needs assessed to include what they needed staff to look out for to ensure the care was effective. Another person's care records which stated something they disliked was "not having legs and being in a wheelchair" had no further details in the section titled "Moving around". This had not been completed for staff to be aware how the person chose to be supported in using their wheelchair. Another dislike listed by the person was "not being able to hear properly"; the section for seeing and hearing was blank with no details for staff to know the person's choices around how best to be supported in them hearing effectively.

Staff were not being offered training apart from in moving and handling. Therefore staff would not have the knowledge of what constitutes best practice guidance such as National Institute for Clinical and Care Excellence (NICE) guidance. This is important as keeping up to date in which practices are current is important in providing effective care.

Staff were supporting some people with meal preparation, eating and drinking. We found people's care plans evidenced this. Daily records were being completed by staff to record when they had supported people to eat and drink. We viewed these and we found staff were not always documenting whether food

and drink had been provided or not despite this being listed as a task in the care plan. We also did not find detailed recordings for people who were unable to recall when they had last had a drink by way of a fluid intake chart to monitor how much the person was drinking to ensure that they were always hydrated. One relative raised concern with us that they were concerned their relative was not always being supported to have enough to maintain their hydration levels. We also found for people who were prescribed high calorie drinks, staff were not clearly documenting if they had offered the person a high calorie drink. Clear documentation is needed for family and healthcare professionals to monitor people's intake of prescribed high calorie drinks according to their prescription to then monitor their weight. This is important to ensure people are receiving an appropriate amount of calories to prevent weight loss or malnutrition.

There was evidence in the records we viewed of healthcare professionals being involved in people's care. One relative we spoke with explained how a staff member had identified a health concern and brought it to the person's attention who was then able to seek advice from their General Practitioner.

We found evidence of regular supervisions and appraisals being undertaken with staff by the registered manager. Staff told us they were receiving supervision.

Requires Improvement

Our findings

We asked people about their care and received mixed views. One relative told us "They are absolutely fantastic, I don't know what we would do without them". A relative explained how staff made their way on foot during adverse weather to provide care. Another relative told us "{staff member} comes in with a smile, you'd never get anyone better than {staff member}."

We received mixed reports from people and their relatives about how people were being respected. Some people we spoke with wished to remain anonymous for fear of reprisals from the provider. They described how they had not received a service which upheld their relative's dignity or demonstrated respect for them. They described aggressive/bullying behaviours towards them by a staff member during a care visit, at times in front of the person receiving care.

We viewed some people had sent compliments to the service such as "we will always be grateful for your caring ways."

The service were not always upholding people's dignity. People who were living with dementia had limited information in their care plan how staff could support them in maintaining their independence.

People's consent or choices were not clearly documented in the care records. People were not being provided with specific times when they could expect to receive their care. The registered manager told us "approximate" times were provided. This meant people were not invited to make decisions about when they received their care.

We looked into whether the service adopted a caring approach and found they had policies for "Privacy and Dignity", "Autonomy and Independence", "Equality and Diversity Policy" and "Equal Opportunities" policies.

The registered manager demonstrated an empathetic approach by explaining how they aimed to deliver care in conjunction with people's wishes. The registered manager had undertaken reviews with some of the 10 people receiving a service. There were a mixture of comments. We viewed one person's wishes had been reviewed. Another person had commented they were unhappy with contingency arrangements for staff sickness which caused delays in them receiving care. An action was seen which demonstrated the manager had listened to them. Another person had asked for a staff member not to return to provide care and this had been acted upon.

The manager had devised a tick box question and answer survey for people using the service. According to the records the survey had last been sent out to people in April 2017. There were nine responses seen all with positive comments for example "Love the staff".

The registered manager told us no one within the service required advocacy services but they were aware of advocacy services offered by Age UK Cheshire Advocacy Services and we viewed the service's advocacy policy.

Requires Improvement

Our findings

We received mixed views about how responsive the service was to people's care needs.

On the last inspection on 3 May 16 the provider was found to be in breach of Regulation 9 Person Centred Care for not having enough detailed information in people's care plans. We found the provider remained in breach of this regulation on this regulation as there was not enough person centred information for staff to provide person centred care.

Of the care plans we viewed we found not all aspects of people's health care needs had been fully assessed. Staff need information on people's healthcare needs to be able to provide person centred care. Staff were therefore, at times unaware of people's specific individual healthcare needs to know how to support the person. For example, people who were prescribed creams did not always have a care plan related to this particular health need for staff to know why the person required the prescribed cream, where to apply it and how often. Another person who was receiving catheter care had no catheter/continence care plan.

People living with dementia had no person centred care plan to provide details about them, family/social history, previous occupation, places of interest, topics of interest, habitual routine or things which provided them with comfort. Staff had limited information to be able to provide person centred care.

The registered manager told us they had implemented a person centred care plan for one person they delivered care for. We viewed this care plan and found further improvements were needed as it did not have enough detailed information. For example, the "All About Me" document stated the person had mobility problems but it did not give enough information how the person preferred to be supported with this.

This is a Breach of Regulation 9 Person Centred Care of the Health and Social Care Regulations 2008 (Regulated Activities) 2014

There was a system of complaints seen and a log held by the registered manager. Two complaints had been logged at the time of our inspection. One of the two complaints had not been recorded in the complaints log to know the nature of the complaint. We viewed the actions taken by the registered manager but no letter of response to the complainant. The complaints policy we viewed stated "a written account of the investigation will be sent to the complainant. This includes details of how to approach the Care Quality Commission if the complainant is not satisfied with the outcome". We did not find a written account of the investigation provided for the complainant in the complaints file.

We recommend the provider reviews their complaints systems to ensure they are robust.

The service were not providing end of life care for anyone at the time of this inspection.

Inadequate

Our findings

On the last inspection on 3 May 16 the service had been in breach of Regulation 17 Good Governance due to the lack of management systems including audits to demonstrate good governance. We found the service remained in breach of this regulation on this inspection as there was a continued lack of quality assurance checks or audits being undertaken.

The registered manager had not identified concerns we found in relation to documentation. Medication administration sheets had not always been completed accurately or clearly. There were no checks being undertaken by the registered manager of medication administration sheets. The management of medicines was a concern on the previous inspection and although medication administration sheets had been implemented they were not always being completed.

Care plans were being reviewed however, the concerns we raised on this inspection had not been identified through the services own quality assurance checks. There were specific risks not identified or mitigated if not for this inspection. The registered manager acted immediately and sought to remedy this by ensuring they mitigated the risks we identified documented within an action plan provided following this inspection.

The registered manager had begun to implement an "All About Me" person centred care plan for one person out of ten people they delivered a service for. There was a lack of person centred information within the care plans for staff to know the person's preferences, background, interests, likes and dislikes. We raised this on the last inspection and found the service had not made enough improvements on this inspection.

The complaints system was not robust. We found no response letter to the complainant which is detailed as required within the service's own policy.

The ongoing training offered for staff following completion of the Care Certificate, was inadequate with no training being offered by the provider apart from moving and handling. The registered manager told us they had no records demonstrating staff competencies. We were concerned the registered manager and provider had not ensured there was a system in place for checking and monitoring staff knowledge, skills and competency to fulfil their role.

A service was being provided for people with capacity to make their own decisions and for people who lacked capacity to make specific decisions. There was no system in place of consent being recorded. Expressed consent can be provided but there must be a system of recording this. We did not find a system

which demonstrated people's consent was being sought lawfully.

Some people we spoke with raised concerns about the leadership of the service and how people were not always treated with dignity and respect.

The Safeguarding Authority confirmed the provider failed to provide them with information they had requested as part of a safeguarding investigation. In view of the registered manager not communicating with the Safeguarding Authority either by telephone or email, the Safeguarding Authority considered it appropriate to hold a professionals meeting. Despite the Safeguarding Authority meeting with the registered manager and requesting the specific detailed information in relation to the safeguarding concern, they did not provide the information requested. The safeguarding concern was substantiated as the absence of care records such as a tissue viability/pressure care plan and body map demonstrated the provider had not ensured the person received a safe or acceptable standard of care. The provider had not maintained contemporaneous records demonstrating how they had delivered care to reduce the risk of the person developing a Grade 3 pressure sore.

This is a Breach of Regulation 17 Good Governance of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.

The registered manager failed to provide the Commission with a statutory notification which is a legal requirement. We had not received a statutory notification to inform the Commission alleged harm had come to a person who had developed a Grade 3 pressure sore.

This is a Breach of Regulation 18 of the Registration Regulations 2009 of the Health and Social Care Act Regulations

Staff were complimentary about the registered manager of the service. People and their relatives also provided positive feedback about the registered manager.

We found the registered manager had sought people's views since the last inspection on 3 May 2016 in a more recent survey in April 2017. Staff supervisions and appraisals were being undertaken for staff to raise any concerns with the registered manager.

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 registered manager failed to notify the Commission which is a legal requirement.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was limited information about people's preferences, likes and dislikes for staff to know how to provide person centred care.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Principles of the Mental Capacity Act 2005 were not being followed with specific consent not always being documented in line with the legislation.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not always being identified or

assessed for staff to know how to mitigate the risks.
Medicines were not being managed safely with medication administration sheets not always being completed.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding procedures were not robust enough. Staff were not knowledgeable enough about different types of abuse to be able to identify abuse.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The risks identified on this inspection had not been identified through the service's own quality assurance checks or audits. There were no medication audits taking place despite this being a concern on the previous inspection on 3 May 2016.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Training offered to staff by the provider was inadequate. Staff we spoke with had limited knowledge in safeguarding and Mental Capacity Act 2005.