Holistic Recruiters Limited

Holistic Recruiters Limited

Inspection report

Suite1, 2nd Floor Middleborough House
Middleborough House
Colchester
Essex
CO1 1QT

Tel: 01206616120

Date of inspection visit:
22 November 2018
26 November 2018

Date of publication:
09 January 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection took place on the 22 and 26 November 2018.

Holistic recruiters are a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older and younger people some of whom may have a physical disability. At the time of our inspection the service provided a regulated activity to 13 people.

There was a registered manager who was also the sole director of the company. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.
This was the first inspection of this service since registration with CQC on the 31 May 2017. We identified major concerns in relation to the quality and safety monitoring of the service. Immediately following our inspection, we wrote to the provider requiring them to inform us of the actions they would take to meet the requirements of the law. We also required the provider to provide us with full information in relation to the numbers of staff employed and details of the people receiving a service. Following their response, we informed the local authority commissioners of our concerns who responded by finding alternative providers for all of the people receiving a service on the same day.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The registered manager did not promote a culture that encouraged candour, openness and honesty at all levels. Throughout our inspection the registered manager provided inconsistent, conflicting, information. They did not have effective systems in place to ensure overall governance of the service and identify the shortfalls we found at this inspection.

People were placed at risk as staff were not provided with the training, guidance and information they needed to keep people safe. Risk assessments were not always in place to address people's needs and reduce the risk of harm. Widespread significant shortfalls in the service meant that people's health, safety and welfare was not upheld.

People were at risk of not receiving their medicines as prescribed. Not all staff who administered medicines had been trained and had their competency assessed to ensure they were safe to do so. Staff did not demonstrate the required knowledge to ensure the safe management of people's medicines.

There were insufficient numbers of suitably qualified staff to meet people's needs. Staff were not recruited safely in accordance with the provider's own policy and procedure. Systems to check that people were

being supported by staff who had the suitable skills, knowledge and qualifications to meet their needs were not robust. Induction training and safety and competence checks had not always been completed before staff were left unsupervised to care for people in their own homes.

Accidents and incidents people told us had taken place were not recorded. Record keeping in relation to the care provided to people was poor and inconsistent. Guidance was not always provided to staff with action they should take to reduce risks to people's safety.

The Mental Capacity Act (MCA) 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The registered manager did not understand their role and responsibilities. People's capacity had not been assessed with information provided to staff in meeting their needs.

Whilst some staff were seen to be kind and caring, people were not always treated with dignity. Further work was needed to embed a culture of caring throughout the service.

There was a policy and procedure for handling complaints, however this was not always being followed. People told us their complaints had not always been responded to appropriately. The registered manager did not record concerns and complaints received in accordance with their own policy which meant complaints had not been dealt with properly. There was a failure to evidence learning from incidents with planning towards improving the service.

No one receiving end of life care. However, staff had not been trained in meeting the needs of people at the end of life. There was no guidance on what to do in the event of sudden death. There was no care plan guidance available to staff as to any assessment of people's wishes in the event of death or if circumstances changed and they needed palliative care.

During this inspection we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the end of this report.

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.

People were placed at risk. Risk assessments were not always in place to address people's needs and reduce the risk of harm.

People were at risk of not receiving their medicine as prescribed because staff did not demonstrate the safe management of medicines.

There were insufficient numbers of suitably qualified staff to meet people's needs. Staff recruitment was not safe because the recruitment process
was not robust.

Accidents and incidents that had occurred were not recorded with action taken to mitigate the risk of further harm.

Is the service effective?

Inadequate

The service was not effective.

Staff had not always received the quality and range of training they needed to meet people's needs and equip them for the role they were employed to perform.

The service did not ensure people always received care in line with the Mental Capacity Act 2005.

People did not always receive the support they needed in relation to their healthcare needs and eating and drinking.

Is the service caring?

Inadequate

The service was not caring.

Whilst some staff were seen to be kind and caring, further work was needed to imbed a culture of caring throughout the service.

People were not always treated with dignity,

Widespread significant shortfalls in the service meant that

people's health, safety and welfare was not upheld.

Is the service responsive?

Inadequate

The service was not responsive.

Staff did not have access to care plans to guide them in meeting people's assessed needs.

There was a policy and procedure for handling complaints, however this was not always being followed.

There was no care plan guidance in place for staff as to people's assessed wishes at the end of life.

Is the service well-led?

Inadequate

The service was not well led.

The registered manager lacked robust oversight of the service and had not
audited the service sufficiently to identify the issues we found.

The registered manager did not promote a culture which was open, honest and transparent.

Systems to check that people were being supported by staff who had the suitable skills, knowledge and qualifications to meet their needs were not robust.

Record keeping in relation to complaints, accidents and incidents, safeguarding incidents, audits and notifications were not robust.

Holistic Recruiters Limited

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.

This comprehensive inspection was carried out on the 22 and 26 November 2018 by two Inspectors.

We gave 24 hours' notice of the inspection visit because it is a small agency and the manager is often out of the office. We needed to be sure that they would be in.

The Inspectors visited the office location on the 22 November 2018 and visited two people in their homes. On the 26 November 2018 we made telephone calls to staff, people who used the service and their relatives.

Prior to our inspection we had not received any notifications from the service. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed this information to assist us with the planning of the inspection.

We spoke with three people and three relatives. We also spoke with Essex County Council contracts team. We also spoke with four care staff, the registered manager, two care coordinators, the deputy manager and two administration staff.

We reviewed the care records of five people. We also looked at records relating to the overall quality and safety management of the service, four staff recruitment files, medicines management, staff meeting minutes and staff training.

Inadequate

Is the service safe?

Our findings

People were not safe and protected from avoidable harm. The registered manager did not fully assess all the risks to the health, welfare and safety of people who used the service. Staff were not provided with the guidance they needed to keep people safe from harm.

The recording and action taken to reduce risks to people's safety, was not clear or sufficiently robust. When we visited two people in their own home we found there were no care plans in place and no access for staff to risk assessments. One person required the use of an electric hoist to mobilise. There was no moving and handling plan in place to guide staff and carry out manoeuvres safely. Another person we visited was diagnosed with Chronic Obstructive Pulmonary Disease (COPD). This is a lung disease with symptoms of increasing breathlessness for which the person was prescribed oxygen administered via a cylinder to breathe. There was no care plan in place and no risk assessments to guide staff as to the use of this equipment and the risks associated with this highly inflammable equipment. The member of staff supporting this person told us, "No, I have not seen any care plan. We just ask [person] what they want us to do and we just do it."

Staff told us they had not read or had access to the care plans we reviewed in the agency office. Risk assessments maintained in the office were a tick box assessment system which did not clearly determine the level of risk and no actions described to reduce risks to people's safety. For example, there were no moving and handling plans for the people who required staff to use equipment such as electric hoists. There was also no reference to equipment needed for pressure relief to prevent the risk of pressure ulcers.

Accidents and incidents were not recorded. The registered manager told us there had not been any incidents or accidents since their registration in November 2017. However, a relative told us of an incident whereby their relative had sustained an injury following a fall into a bath whilst being supported by two care staff. They told us, "They [staff] did not appear to be very well trained. They did not support [relative] properly when they were getting into the bath. After the accident they did not appear to know what to do. They also didn't record anything on the daily notes, I had to remind them later to write something. I was not impressed, even I know they should be writing about what had happened. They didn't call the GP, they just left. The next day [relative] moved into a care home and the staff at the home were so concerned about the injury to my [relative's] ribs, they called the GP to take a look." The relative also told us, "As far as I am aware there never was any care plan in the folder they gave us. Certainly nothing that would tell the staff about helping [relative] into the bath safely." Immediately following our inspection, we raised a safeguarding alert with the local safeguarding authority with regards to this incident.

For one person staff had recorded in daily notes, on three occasions over a two month period between July 2018 and August 2018 they had observed blood in the person's urine when emptying their commode. They also recorded on one occasion, 'I believe [person's name] has a urine infection.' However, there was no follow up action recorded to show what if any medical attention had been sought. We discussed this with the registered manager who told us he was unaware of any follow up action taken and said, "This is a problem we have with staff not doing what they should." The registered manager also confirmed that

management audits of care records had not taken place which would have identified this issue. We visited this person in their home where there was no care plan in place to guide staff in meeting their needs including any medical health needs. We also noted this person required four calls daily and there were several days for the last month where staff had not recorded any care provided.

Not all staff who administered people's medicines had received training or competency assessment to confirm they were safe to do so, as required. Care plans contained conflicting information as to who administered people's medicines. For example, one care plan stated the person's family administered their medicines. However. staff supporting this person told us they carried out this task. There was no medicines administration record (MAR) available in the person's home for staff to record when they had done so.

A review of one person's MAR record showed several days where staff had not signed to evidence this person had received their medicines as prescribed. There were no medicines management audits carried out which would have identified the shortfalls that we found.

Where people were prescribed topical medicines such as creams and lotions there was no body map in place and no support plan instructing staff as to where to apply the prescribed medicine. This meant people could not be assured that staff were administering their medicines as prescribed with the required knowledge to maintain people's health and welfare.

These shortfalls demonstrated a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were not protected from being cared for by unsuitable staff because robust recruitment procedures were not in place. Staff had not been employed in line with the providers own policy and procedure and systems in place were not sufficiently robust. Safety checks had not been carried out prior to staff working unsupervised. We found three staff recently employed whereby the registered manager had not obtained references prior to or since their employment. For two staff Disclosure and Barring (DBS) criminal records checks had not been carried out. We found conflicting information within staff application forms which had not been explored to confirm gaps in previous work history and confirm the last place of employment.

This demonstrated a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There were insufficient staff to meet people's needs. The registered manager told us during our office visit that they had sufficient numbers of staff but were recruiting new staff to enable them to take on more care packages. However, one relative told us, "We have been served notice to say they are cancelling [relative's] care with Holistic Recruiters because they do not have enough staff. Yet we don't know what will happen." Another relative told us, "My [relative] has had calls missed where staff don't turn up or are running late. Staff tell us there is not enough of them. Some of the staff live in London and must travel all the way to Colchester and they don't drive. They rely on a driver to drive them around, it is clearly not working very well."

Several staff told us they did not drive and relied on a driver employed by the agency to take them from one person to the next. This system they said, was not always effective and meant they were often late for visits. They also told us they sometimes relied on buses for transport which were not always on time and resulted in their being late to provide care.

Following receipt of feedback from people we asked the registered manager if what we had been told was

true regarding people's care being cancelled due to shortages of staff. They confirmed that this information was correct. They confirmed they had given notice to all the people placed by Essex County Council because they did not have enough staff to meet people's needs. This information conflicted with what the registered manager had told us during our visit to the agency.

The registered manager operated a recruitment agency alongside Holistic Recruiters domiciliary care service where they provided staff to care homes as well as the community. They told us staff who provided care to people's in their own homes did not also work for their recruitment agency in care homes. The registered manager told us they wanted to keep the two business separate from one another. However, staff told us this was not the case as some of them worked across both but without appropriate safeguards in place. We saw from a review of staff time sheets that one member of staff had worked during the day providing care to people in the community and was then allocated to work an awake night shift within a care home. This meant that consideration had not been given to ensure staff had sufficient time to rest, to be alert and respond to the needs of people who used the service in a safe manner.

This demonstrated a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff told us they had access to personal protective equipment to safeguard themselves and people from the risks of infection. However, there were no care plans or risk assessments in place which would guide staff as to any infection control measures in place. For example, when emptying commodes and the disposing of urine and faeces.

Inadequate

Is the service effective?

Our findings

The registered manager did not ensure all staff had the skills, knowledge and experience to meet the needs and promote the wellbeing of the people they supported.

The registered manager told us when asked within their provider information return (PIR) what plans they had to make their service more effective. They told us, 'We consider that effective delegation is at the heart of a well-led service. Our aim is to provide staff with as much responsibility as they are capable of in the context of their job descriptions and their professional development goals. Holistic Recruiters are attempting to develop some of our experienced staff as champions by encouraging and enabling individual staff to build up expertise in different areas of care practice such as dignity, dementia care, end-of-life care, activities, safe use of medicines, and management of specific conditions such as diabetes, epilepsy, Parkinson's or strokes, anything that reflects service users' needs. This will involve champions carrying out supervision of practice in their area of expertise and staff training to cascade their knowledge and skills.'

However, our findings did not reflect this. Staff were not provided with opportunities to discuss their performance, training and development needs. The registered manager confirmed they had not carried out any formal supervision meetings with any of the staff employed. They told us, "We just phone them when we need to." This they confirmed did not comply with their own staff supervision policy.

There were some recorded meetings involving office staff where ideas were shared and discussed in relation to 'attracting more business'. However, there were no opportunities for care staff to meet as a team to air their views, concerns, discuss the care of people, share learning or opportunities to be involved in planning for improvement of the service.

The registered manager told us they were accredited as a trainer and provided all the training staff received. However, they were unable to evidence their accreditation to do so in subjects such as moving and handling, emergency first aid and health and safety risk management.

There was no evidence that newly employed staff had received an induction prior to their working alone. One member of staff told us, "I shadowed another member of staff for one day before I then worked alone." Another newly employed member of staff said, "I have not had any induction, it is a shamble, they [the registered manager] has no idea what they are doing."

Staff told us they received training through watching videos in subjects such as the moving and handling, safeguarding, food hygiene and fire safety. None of staff we spoke with confirmed any training had been provided in meeting the needs of people living with dementia. They also said they were shown how to use a hoist and lifting equipment by 'practising on people in their own homes alongside other care staff'.

The number of concerns we identified regarding the care and support provided to people throughout our inspection meant that the training provided was not effective, considered best practice, and was imbedded into staff practice. Poor practice in the assessment of safe moving and handling, risk assessment,

responding to the needs of people living with dementia and mental capacity impacted on the quality of care being provided. This meant there was a lack of a learning culture being promoted to ensure people's safety and wellbeing.

This demonstrated a breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take 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.

We were not assured from discussions with staff, our observations and a review of care records that staff and the registered manager fully understood their roles and responsibilities in relation to the Mental Capacity Act 2005. Staff we spoke with could not give us accurate information
about the principles of the Mental Capacity Act 2005. However, there was no indication that people were not given choices or opportunity to consent to their care. People using the service and their representatives told us they were involved in making decisions about their care and had consented to this.

Staff were not provided with effective behavioural management plans and strategies based on best practice guidance. For example, office staff told us when describing the needs of one person, "Presents with very challenging behaviour and can be aggressive"; However, there was no information as to any behavioural management strategies to guide staff. There was no planning as to any restrictions on this person's freedom of movement and assessment of their capacity to consent to personal care.

Information sharing and communication with other services was poor. The registered manager did not make referrals as required for appropriate care and treatment in a timely manner. We were not assured people were supported to access healthcare services when they needed as referenced earlier within the safe domain. For example, in relation to the person with blood found in their urine where staff had not described any actions taken to access healthcare support. Also with regards to the person who fell in the bath and sustained an injury whilst assisted by staff. This meant that there was a lack of action to ensure people received the medical care they needed.

The service did not ensure that people had enough to eat and drink throughout the day. Where people required support with the preparation of food and drink at the two homes we visited, there were no care plans in place to determine and guide staff as to how people's needs would be met. One relative told us, "They do not always make a drink and leave sandwiches after the lunchtime call to ensure [relative] has them for their tea."

Inadequate

Is the service caring?

Our findings

We received mixed views from people about the caring nature of staff. Comments included, "Some of the staff are nice, but some hardly speak to you." And, "One member of staff doesn't take off her coat and hat and is always rushing for the bus or for the driver collecting her. I have had to tell [member of staff] to take of her coat when giving me a wash."

There were widespread serious shortfalls in the service provided to people which meant that their immediate needs, safety and wellbeing did not benefit from a caring culture. Further work was needed to imbed a culture of caring throughout the service. Staff were not supported by the management of the service to ensure that people were provided with sufficient staff available always to meet their needs. Staff were not provided with sufficient information about people's personal histories or preferences in how their care and treatment was provided.

People were not listened to and there were no formal systems in place to ascertain their views about their care and make improvements. One person whose only care plan was held in the agency office stated, '[Person] has requested no male carers to be allocated'. However, this person and their relative confirmed that a male. member of staff had turned up without notice to provide support with the person's personal care that morning. The person also told us they had not been consulted prior to this change of carer to obtain their views as to this change and their consent.

Staff routines took priority over human rights and preferences. People told us the care staff who supported them maintained their privacy and dignity when providing personal care behind closed doors and with closed curtains. However, one person told us that there had been occasions when only one of the two staff needed would turn up to help them mobilise to access their bathroom. With only one member of staff attending this meant staff working alone could not use the electric hoist. The person using the service said, "They couldn't help me to go to the bathroom and told me to "just do it in your pad". The person described how this, "robbed me of my dignity" and left them feeling "degraded".

People were not involved in their own care and support in a way that makes them feel that they matter. The registered manager did not always provide consistency with the care staff allocated. People told us they were not informed who would be attending to their care and if staff were running late. People said care staff did not always know their routines and they would have to tell staff what was needed and how they liked to be supported. This meant people were not enabled to build a rapport with named staff and did not provide continuity of care.

Inadequate

Is the service responsive?

Our findings

The service was not delivered in a way that ensured people's care was planned and delivered with their involvement to fully reflect their physical, mental, emotional and social needs. The registered manager did not put in place care plans available to staff in people's homes, produced involving people and their relatives/representatives in the process.

During our visit to the agency office on the first day of our inspection we were shown copies of care plans for what we were told was the only five people using the service. When we visited people in their homes there were no care plans available for people to review and to provide staff with guidance as to the care and support provided. People told us they had not been involved in the planning of their care or any review of care plans. All staff we spoke with told us they had not been provided with any care plans other than the initial assessment information provided by the placing local authority. Staff told us they were reliant on people telling what they needed to do.

Where people presented with behaviour that may present a risk to themselves and or others there was a lack of behavioural management strategies available for staff. Staff therefore did not have sufficient guidance to ensure people's rights were being protected, their safety and welfare robustly assessed and monitored with action described to safeguard the person's wellbeing.

We found frequent gaps in people's daily logs which meant we were not assured staff had visited the person as required. One person told us, "They don't always turn up when they should." Where staff had recorded information, this was often brief and did not evidence the full range of care required. For example, where people needed support with baths or showers. Where people had been assessed as at risk of losing weight there was not always a record of food and drink provided. This meant people could not be sure staff had done all that was reasonably practicable to mitigate risks to their health, welfare and safety.

This demonstrated a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There was no one receiving end of life care at the time of our inspection. There was no information within care plans which would provide guidance as to people's assessed wishes in the event of death and should their needs change and they need palliative care. Staff had not been provided with training in meeting the needs of people at the end of life.

There was a policy and procedural guidance in place for receiving and handling complaints, however this was not always being followed. The registered manager did not have an effective system in place to evidence they took people's concerns and complaints seriously. The registered manager told us they had not received any complaints. However, people and their relatives told us this was not the case. One relative told us, "I have had to phone the office to complain that my [relative] was left without a drink and on another occasion phone up to complain they did not leave [relative] with a sandwich for their tea time meal." Another relative told us, "We have had to complain about the lateness of staff. I wouldn't know if

there was any formal complaints system."

This demonstrated a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

There was a registered manager who was also the sole director. We found widespread and significant shortfalls in the way the service was led.

The registered manager did not promote a culture that encouraged candour, openness and honesty at all levels. Throughout our inspection the registered manager persisted in providing inconsistent, conflicting information. For example, the registered manager told us everyone they provided a service their care had been commissioned by two local authorities with no one privately funding their own care. Following discussions with staff and people who used the service we found this information was incorrect. When we questioned this with the registered manager they told us that the privately funded people identified no longer received care from Holistic Recruiters. However, we spoke with one person funding their own care and who was still in receipt of care from Holistic Recruiters. This was also confirmed by the care staff who supported the person.

The registered manager told us when we announced the inspection the day prior to our visit to the office that they employed three staff who provided care and support to only three people. On the day of our visit to the office they gave us a list of five staff and a list of five people in receipt of care. When we reviewed daily logs in people's homes and spoke to staff we found names of additional staff working for the agency and people in receipt of care of which we had not been informed. Immediately following our inspection we formally requested the registered manager provide us with the correct information as to the names and numbers of staff employed and the people they provided a service to. In their response they informed us they actually provided a service to 13 people and employed 14 staff. The registered manager told us the reason they gave for not providing the full list of staff was because the additional staff had only recently been employed. However, one member of staff told us they had been employed by Holistic recruiters for in excess of 12 months and others had been working unsupervised for at least one month.

The registered manager did not have systems in place to ensure effective quality and safety monitoring of the service. They did not understand the principles of good quality assurance and planning for improvement of the service. There was a lack of management oversight and system of auditing which would have identified the shortfalls we found at this inspection.

Systems to check that people were being supported by staff who had the suitable skills, knowledge and qualifications to meet their needs were not robust. People told us they were supported by staff who, "Appear not to know what they are doing." And, "They are all young, students who clearly have not had the training they need. They turn up in skimpy clothes without uniforms and no ID." There was a lack of overall governance where systems had failed to identify that staff had not received training and information about people's specific support needs and aware of associated risks.

There was no process in place to ensure staff received supervision support in line with the registered manager's own policy. For example, the registered manager did not carry out spot checks to assess staff performance. There was no system in place to ensure staff supervision and team meetings occurred at the

regularity as stated in procedural guidance. This meant staff did not have opportunities to discuss their training and development needs with updates in the latest best practice and guidance. There was a failure to maintain robust training records which meant people were at risk of being supported by staff who were unable to meet their specific needs.

Systems to monitor if there were enough suitable staff on duty so people were supported safely were ineffective. The registered manager did not record and monitor missed calls. One person told us, "I did not receive a call last night, the staff did not turn up to help me to bed. I called the out of hours number only to be told by who I think was the man in charge, 'We are miles away and do not have time to do your call.' I had to call them, they didn't call me, I was just left waiting not knowing what was happening."

There was no effective system in place to engage with people who used the service and respond appropriately to feedback about the quality and safety of the service. People told us that when they wanted to raise concerns, their calls to the office were not always answered or staff would not always call them back. One person told us, "If you have a query they don't always come back to you."

Record keeping in relation to complaints, accidents and incidents, safeguarding incidents, audits and notifications were either missing or lacked details and completeness. The registered manager told us they had not received any complaints or concerns and had there had been no accidents or untoward incidents to record. However, people and their relatives told us they had raised concerns with the registered manager about late calls, missed calls, staff not recording care provided in daily notes and food not provided when this was part of their care package.

Where people told us incidents and accidents had occurred, these had not been recorded with actions taken to mitigate further risk of harm. Systems had not ensured concerns about people's care and exposure to the risk of harm were responded to. Failure to have effective systems to respond to feedback prevented prompt, effective action and improvements being made to how the service was run and the quality of care people received.

People's comments on the quality of the leadership included. "I have no idea who the manager is. They have never introduced themselves to me. I suspect the manager is the same person who drives the staff around. He came into my house once and never introduced himself, just stood there checking on the staff I think." Another person said, "I think the [care staff] are good in the main but I don't know who the staff in the office are or who the manager is." A relative told us, "The service is just so disorganised, they clearly don't know what they are doing."

This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.