Brooks Care and Nursing Services Limited

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Inspection report

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10 January 2017
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16 January 2017
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19 January 2017
24 January 2017

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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 was completed on the 10, 11, 16, 18, 19 and 24 January 2017.

Brooks Care and Nursing Services Limited is a domiciliary care agency registered to provide personal care for adults living in their own homes. At the time of our inspection care was being provided to 158 people. The service does not provide nursing care.

Two registered managers were in post who were also the owners of the business. 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 our inspection we identified a number of concerns about the care, safety and welfare of people who used the service. The quality assurance processes in place at the service were not robust enough to assess, monitor and mitigate the risks relating to the health and welfare of people using the service and to drive service improvement. We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of this report.

The service did not always have sufficient numbers of care workers who were effectively deployed to meet people's needs. Care workers were not allocated travel time between call visits and told us they often had to pick up additional call visits. The service had no systems in place to robustly monitor late and missed call visits.

Care workers understood the risks and signs of potential abuse and the relevant safeguarding processes to follow, however the service did not keep succinct records of safeguarding allegations, accidents and incidents and had no structured procedure in place to analyse these. Also, the service had not submitted notifications relating to allegations of abuse to the Care Quality Commission in line with Regulations. Improvements were required to safely assist people with the management of their medicines and ensure people received their medication as prescribed.

Improvements were required to ensure care workers received regular structured supervision and training to enable them to keep their skills up to date to meet people's needs effectively. Most of the care workers we spoke with had limited knowledge of the Mental Capacity Act 2005 (MCA) and the service had not adhered to the principles of the MCA. People's nutritional needs were not always met as, although feedback from people was generally positive, we found care plans contained limited information on people's dietary and nutritional needs and associated risks. Where required people were supported to access healthcare professionals.

Although most people told us that care workers were kind and caring and that they were treated with dignity and respect, some people and their relatives said that care workers did not always know their needs and preferences for how their care and support should be delivered. Improvements were required to ensure care plans contained sufficient information and guidance to ensure that care was provided appropriately by care workers in line with people's individual needs and that risks relating to people's health, safety and welfare were mitigated.

There were processes in place to seek the views of people who used the service and those acting on their behalf but it was unclear how this feedback was used effectively to improve the quality of the service. Improvements were required to ensure people's concerns and complaints were acted upon.

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 consistently safe.

Improvements were required to ensure risks to people's safety and wellbeing were appropriately managed.

Staffing levels were not sufficient to meet the needs of people using the service. Care workers did not have allocated travel time between call visits resulting in late calls and visits being cut short.

Care workers had received safeguarding training and were aware what actions to take if they had concerns that people were being, or at risk of being, abused. However, the service did not keep succinct records of safeguarding information, accidents and incidents and had no structured procedure in place to analyse these.

People's medicines were not always safely managed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not received regular supervision and appraisal or observation of practice.

The service used several systems to monitor training. Information on these systems was contradictory and it was unclear which staff had completed training.

Not all staff were able to demonstrate an understanding of the Mental Capacity Act 2005 (MCA) and the service had not always acted in accordance with the principles of the MCA.

Although feedback from people was generally positive, care plans contained limited information on people's dietary and nutritional needs and associated risks.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always receive their call visits at their preferred times and call times were sometimes erratic.

Most people told us they were treated with kindness, dignity and with respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were not person centred and did not contain detailed information and guidance to staff. Care plans had not been reviewed to ensure they reflected people's current care and support needs.

Although the registered provider had a complaints policy in place it was unclear how concerns and complaints were being effectively monitored.

Is the service well-led?

Inadequate

The service was not well-led.

The registered provider did not have robust quality assurance systems in place to effectively monitor and evaluate the quality of the service and the registered managers were unable to demonstrate effective leadership and governance.

There were systems in place to seek the views of people who used the service and those acting on their behalf but it was unclear how these were used effectively to improve the quality of the service.

Regular care worker meetings were not held.

Brooks Care and Nursing Services 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 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 inspection took place on the 10, 11, 16, 18, 19 and 24 January 2017 and was announced. The registered provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. The inspection team consisted of two inspectors and an Expert by Experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service including statutory notifications we had received from the service. Notifications are changes, events or incidents that the provider is legally obliged to send us. We reviewed safeguarding alerts and information received from a local authority. We also reviewed a Provider Information Return (PIR). A PIR 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.

During our inspection we spoke with 20 people who used the service, eight relatives, one health and social care professional, nine members of staff, the quality assurance officer and the registered managers. We looked at a range of records including 15 people's care plans and records, eight staff files, staff training records, staff rotas, arrangements for the management of medicines, a sample of policies and procedures and quality assurance information.

Requires Improvement

Is the service safe?

Our findings

The service did not always have sufficient numbers of staff who were effectively deployed to meet people's needs. People and their relatives told us that care workers were often late and sometimes missed their call visits altogether. Comments included, "They are sometimes late because they are very busy." And, "They forgot my morning call and I was left in my chair; I was in a right mess." Another person said, "Sometimes the timing is erratic particularly in the afternoons and evenings; I have had to wait until 7pm to have my tea."

Five out of eight care workers we spoke with told us that they felt there were not always enough staff and felt pressured to take on additional calls. One care worker said, "There is not enough staff as we have to cover other calls which then leave us feeling exhausted due to how much work we have in such a small amount of time and not spending enough time with the clients." Another said, "Weekends are horrendous as staff tend to call in sick. The other day I started work at 06:30 and got back home at 22:45; this can have an impact."

Staffing levels were not sufficient to meet people's needs. We requested information for the period 12 December 2016 to 15 January 2017 to show how visits were planned. We found that visits were 'back to back' leaving care workers no time for travel between call visits. Additionally some care workers had been rostered to attend calls at the same time in two different locations. We also reviewed a sample of people's care plans and daily communication records and found visit times did not always reflect the commissioned hours in place for individuals as care workers had not stayed for the agreed length of time. During a home visit we saw that the daily record for the person's morning call had not been completed. This meant that it was unclear whether the person had received the care and support they needed. The registered managers were unable to demonstrate to us how they effectively monitored missed and late calls, staffing levels and the deployment of care workers. This meant people were placed at risk of harm and neglect.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst some people told us they received their medicines as they should and at the times they needed them, the arrangements for the management of medicines were inconsistent and unsafe. One person told us, "When I don't have my medicines on time I am left in pain." Another person said, "When the lunch time call was missed it meant seven hours without fluid or medication." Care plans were not clear regarding the level of support people required to take their prescribed medicines safely and did not contain appropriate medication risk assessments. The care plans we looked at did not contain a list of the medicines to be administered or information on the purpose or proposed side effects of the medicines. Where people were prescribed PRN, 'as and when required' medication such as pain relieving medicines, there were no protocols in place to explain when, why and how the medication was to be given.

We reviewed seven Medication Administration Records (MARs). We found unexplained gaps on people's MARs which had not been investigated; it was unclear whether people had received their medicines or not, and if not, the reason why it was not recorded. Furthermore where people received time specific medicines for example 30 mins before or after food it was unclear from the MARs what times these medicines had been

administered. During a home visit we saw a note written by a care worker stating that they had supported the person to take medication which was not included on their MAR. No formal record had been made by the care worker in the daily communication notes and it was unclear who had administered the medication. Furthermore during another home visit we observed staff signing the person's MAR stating they had been supported to take their prescribed medicines before they had actually received and taken them. Where people were prescribed a transdermal patch at specific intervals, the site of application was not recorded so as to demonstrate that the position of the transdermal patch was being rotated to avoid skin irritation. A transdermal patch is a medicated adhesive patch that is placed on the skin to deliver a specific dose of medication through the skin and into the bloodstream over a period of time. Additionally, where people were prescribed a variable dose of medication, for example one or two, the specific dose administered had not always been recorded. This meant that people were at risk of receiving too much or too little medication. The lack of quality monitoring of this element of people's care meant that people's health and wellbeing was placed at risk.

The service had good practice guidance in place for the handling of medication errors, incidents and near misses which stated ' there should be a regular schedule for investigating and reviewing medication errors, incidents and near misses by a designated member of staff'. Records showed only one medication error record for December 2016. The quality assurance manager told us that care workers would be required to undertake refresher training following any medication error. We noted the actions from the incident in December that the person's family were informed and the care worker was spoken with. There was no record of the outcome of the discussion with the care worker or whether they had undertaken refresher training. No medication management audits had been undertaken and there were no robust systems in place to fully investigate medication errors. We discussed this with the registered managers who had no oversight of medication errors; they immediately took steps to put in place systems to ensure medication audits were undertaken which would be reviewed and discussed at monthly managers meetings. All care workers were responsible for supporting people to take their medicines however training records showed that 98 out of 113 care workers had completed medication training. Furthermore no ongoing competency checks had been undertaken to ensure they remained competent to administer medicines safely.

People's care plans contained a generic risk assessment of people's environment and a risk assessment tool. The risk assessment tool which covered areas of care such as mobility, special risks, sitting and comprehension was used to determine whether people's dependency levels were high, medium or low. However the care plans we looked at lacked sufficient detailed information to support care workers on how to effectively and safely mitigate risks for example to prevent the risk of choking, safe moving and handling and for time specific medicines. We discussed our concerns with the registered managers and quality assurance manager who told us they would immediately review their processes and ensure regular audits were completed to ensure people received their medications safely and that care plans contained appropriate risk assessments and guidance for care workers.

The above is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People told us they felt safe when care workers visited and some people said that their regular care workers would always telephone them in advance if they were going to be late however this was not consistent practice across the service.

Although the service had safeguarding and whistleblowing policies in place and staff were trained in recognising signs of abuse, there were no effective processes in place to demonstrate that safeguarding incidents had been appropriately investigated and followed up. This meant we could not be assured that

the service learnt from safeguarding incidents. Staff we spoke with understood the importance of protecting people, keeping them safe and how to respond appropriately where abuse was suspected. However not all staff were aware they could contact external agencies such as social services or the Care Quality Commission (CQC) to report concerns; this information was not included in the service's policies.

The service did not keep succinct records of safeguarding information and accidents and incidents. We were aware prior to our inspection that a number of safeguards had been investigated by the local authority however we found the service had no structured procedure in place to analyse safeguards. We found that the service had failed to recognise and report safeguarding incidents. For example we saw one record where a person had told a care worker about an alleged domestic incident. The care worker had reported this to the office but no safeguard had been raised by the service to protect the person from avoidable harm and abuse. The service had also not notified CQC of safeguarding incidents. Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. Following our discussion with the registered managers they understood and agreed that notifications concerning allegations of suspected abuse should be sent immediately to us.

This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider did not have effective systems in place to monitor and learn from accidents and incidents. Incident and accident records were recorded on two systems and were not audited to ensure any trends or concerns were identified. We could not be assured that the registered managers had an overview of accidents and incidents and therefore was unable to identify any trends or put measures in place to prevent reoccurrence. We discussed our concerns with the registered managers who immediately developed procedures to ensure monthly audits were undertaken and discussed at monthly managers meetings.

There was an effective recruitment process in place to ensure that the right staff were employed at the service. This included dealing with applications and conducting employment interviews. Relevant checks were carried out before a new member of staff started working at the service. These included obtaining references, ensuring that the applicant provided proof of their identity and undertaking a criminal record check with the Disclosure and Barring Service (DBS). Staff told us, and records confirmed, they were not allowed to start working at the service until their references and DBS checks had been completed.

Requires Improvement

Is the service effective?

Our findings

The service was not always effective. Improvements were required in how care workers received regular structured support and training to ensure that their skills were up to date to meet people's needs effectively. Not all care workers we spoke with were able to tell us when they had last received supervision. We checked supervision records and found care workers had not received supervision and appraisal in line with the service's supervision policy which stated, 'Community carers will be formally supervised at least two times in the year. In addition there must be written evidence of at least one supervision session on-site to include direct observation of the carer at work.' This meant care workers did not have a structured opportunity to discuss their practice and development to ensure that they continued to deliver care effectively and safely to people. We discussed this with the registered managers who told us they were aware of the lack of supervisions and were in the process of addressing this.

The service employed a training manager who was responsible for interviewing, inducting and training care workers. They were based in a facility close to the office which had been set up with the necessary resources required to deliver training, for example hoists, beds and catheters. The training manager told us care workers came in during their own time to complete training and they were looking at more flexible ways of delivering training, for example on Saturdays to support care workers with family commitments. However, one care worker told us, "I have had no refreshers on moving and handling, the training has been on the rota but I have had to complete calls." Another said, "I have had no refresher training for medication administration." Training records showed that 92 out of 113 care workers had received health and safety and fire safety training and 94 out of 113 care workers had completed first aid training. Records showed this was one of the service's mandatory training courses that was to be provided every three years. Moving and handling training was also one of the service's mandatory training courses and was required to be updated yearly. Training records showed that 59 staff were waiting for refresher training. The registered managers advised dates for this training had been organised. Training records were kept on several systems and therefore we could not be assured whether care workers had or had not received training in line with the service's policies and procedures as the systems provided conflicting information. The training manager said they were in the process of updating staff training records and checking that the information held on the service's electronic system was correct. Where training had been delivered, there had been no oversight or assessment of how effective the training had been or how care workers were implementing their learning to ensure people's safety and wellbeing.

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received a four day induction when they started work at the service which included an introduction to the service and training. One care worker told us, "I had to do training before I started and shadowed another member of staff to get to know the nature of the job and getting to know people and their needs." The training manager told us they undertook observations of care workers' practice but were unable to show us documentation that this had taken place. They went on to say that they were looking at setting up 'care coaching' which senior carers would be responsible for implementing to ensure staff were competent

in their role. We discussed the Care Certificate with the training manager. They was unaware of the Care Certificate which is a work based achievement aimed at staff who are new to working in the health and social care field and covers 15 essential health and social care topics.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. Domiciliary care services must apply to the Court of Protection for legal authorisations to deprive a person of their liberty.

We checked whether the service was working within the principles of the MCA. Not all of the care workers we spoke with were able to demonstrate an understanding of the MCA and how they should apply the MCA within their day to day practice with regard to protecting people's rights and how people's ability to make informed decisions can change and fluctuate from time to time. Training records showed that only 26 out of 113 care workers had received MCA training. Where people lacked capacity care records did not show that their mental capacity had been assessed and any decisions had been made in their best interests in the least restrictive way in line with legislation. Additionally, although care records did contain signed consent agreements to care and support from people using the service, we noted some of these had been signed by a Lasting Power of Attorney (LPA). A LPA is a legal document that lets you appoint one or more people to help make decisions or to make decisions on your behalf. There are two types of LPA: health and welfare and property and financial affairs; one or both of these can be chosen. We asked the registered manager for documentation showing which LPA was specified. The registered manager informed us they had not seen copies of the documentation and advised they would immediately contact families to bring it in. This meant that the registered manager and staff were unaware of which decisions should involve people's relatives. The service was not acting in accordance with the principles of the MCA to ensure that people who lacked capacity was assessed and decisions were being made in their best interests where they were unable to do so.

This was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Although people told us they were happy with the support they received from care workers to prepare their meals and drinks we found care plans contained limited information on people's dietary and nutritional needs. This included their preferences and guidance for care workers to follow to ensure people's needs were met. For example where people required specific diets such as 'soft' diets there was no information about why they required a soft diet, what types of food they could have or any risk assessments in place associated with their swallowing of food. Food and fluid intake charts were used by the service. We looked at one person's chart where commissioners had requested food and fluid intake charts were completed daily. We saw that charts had not been fully completed by care workers or had not recorded the actual amount of fluid intake/food eaten; this placed the person at risk of not receiving adequate intakes. We noted no information had been recorded regarding the person's food and fluid intake for the period 2 January 2017 to 18 January 2017. We shared our findings with the registered provider who told us they would address them.

People were usually supported by family members to access health care appointments however people told us care workers were helpful if they felt unwell or needed help for example assistance to contact their GP surgery. One person told us, "They called an ambulance for me once when I had trouble breathing."

Requires Improvement

Is the service caring?

Our findings

Although people told us that most of the care workers were caring and treated them with kindness, we received mixed feedback about the attitude and care of care workers. Some people told us that care workers did not always know their needs and preferences for how their care and support should be delivered. We received more positive feedback from people who received care and support from consistent care workers. Comments included, "The regular girls are very good." Another said, "They are so kind and good and don't make me feel stupid." A relative told us, "When [Names of regular care workers] are here I have no worries as they are very caring, have common sense and know how to treat and handle [person's name]."

People were not always treated with dignity and respect. Care workers were able to describe how they treated people with dignity and respect. One told us, "We treat all service users as individuals, communicate with services users by listening to their wants and needs, making them part of every decision regarding their care, and explain how the care is carried out." Although most people told us they were treated with dignity and respect, one relative told us, "They don't talk to [name of person], lack of human dignity." During a home visit we observed one care worker trying to locate where a transdermal patch had been sited whilst the person was trying to eat their lunch showing total disregard for the person. Records also showed that care workers did not always stay for the allocated visit time. For example we saw that for one person who required a 30 minute visit that they received their care delivered in 15 minutes. This demonstrated that care workers were sometimes task focused and not able to have any meaningful period of time with people or focus on their wellbeing. People and relatives also told us that care workers were often late. This meant people were not receiving the care and support they required such as being supported to get up and retire to bed, support with toileting or receiving time specific medicines when required.

Some people and their relatives confirmed they had been present when the service had visited for the initial assessment. One person said, "I was involved in saying what I wanted initially but now I keep a list of what I want them to do." However we found that the majority of care plans had not been reviewed and/or updated. This meant that people were at risk of not receiving care and support which met their current needs.

Care plans contained sections on people's social interests, religious and cultural needs. We saw that this section of people's care plans had not always been completed and, where information had been recorded, there was limited information with regard to how this reflected on how they wished their care to be delivered. We also found that there were no end of life care plans in place. We discussed this with the registered managers who informed us that they would immediately address this and ensure appropriate end of life care plans were in place to ensure care workers were aware of people's wishes and that people had dignity, comfort and respect at the end of their life.

For people who needed extra support to make decisions about their care and support, the service had information about advocacy services. Advocacy services help support and enable people to express their views and concerns and provide independent advice and assistance where needed.

Requires Improvement

Is the service responsive?

Our findings

People using the service told us they were happy with the care and support they received. However, although care workers we spoke with intuitively knew people's needs, we found that care plans did not always contain sufficient information and guidance to ensure that care was provided in a way that appropriately met people's individual needs. We reviewed 15 care plans and found a lack of detailed information and guidance in care plans to enable care workers to effectively and safely care for people in line with their specific care needs, or that the risks relating to people's health, safety and welfare were mitigated. Care workers also told us they did not always have time to read people's care plans before providing care and support. This meant there was a risk of consistent care and support not being provided and that people were not at the centre of the care and support they received because sometimes care workers were focussed on the task rather than the people they were caring for.

No formal care plan audits had been undertaken which meant that people were at risk of not receiving safe and effective support in regards to their health, wellbeing, and nutritional needs. For example, on reviewing one person's care plan we noted that the commissioning package stated the person had specific dietary needs. We found none of this information had been transferred to the person's care plans thereby placing them at risk of aspiration. On reviewing another person's care records we found two letters from healthcare professionals dated 1 December 2016 and 9 January 2017 updating the service on the person's dietary needs. The care plan for this person had not been updated to reflect these changes. Records showed that people's care plans had not been reviewed every six months in line with the service's policy and procedures. During a home visit we observed a person informing care workers how they were uncomfortable as their head was hitting the bed rail to the side of their bed. The care worker went on to tell us that there was also an issue with the person's slide sheet. They told the person that they would inform the office so they could take appropriate action. When we returned to the office four days later no contact had been made and management were unaware of the issues and no action had been taken to change the way the person was receiving their care.

This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a policy for managing complaints. We received mixed feedback from people and relatives including, "I have made one complaint which was handled well, mum wouldn't like saying anything because she wouldn't want to upset anyone." And, "I spoke to the manager about different people [staff] all the time; there was no comment or action." Although there was a complaints system in place it was not consistently or effectively managed. Prior to undertaking our inspection we had been contacted by relatives who were unhappy about the service being delivered to their loved ones and felt their concerns were not being listened to. One relative told us they had attended a meeting with management concerning late and missed calls. They went on to say that the service had promised them that they would rectify the issues however during our inspection they informed us that the issues regarding late and missed calls and general lack of care for their loved one continued. Records showed one formal complaint had been logged for the service. The service did not have a structured process for recording, investigating and learning from complaints. We

found that the registered managers had no overview of concerns and complaints and we were not assured that people's concerns and complaints had been responded to appropriately.

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

Appropriate arrangements were in place to assess the needs of people prior to them using the service. Assessments were undertaken to identify people's health, personal care and social support needs and, where possible, the assessment included the involvement of families. Information from the initial assessment was used to develop people's care plans.

Inadequate

Is the service well-led?

Our findings

There were two registered managers in post at the time of our inspection who were also the registered provider. They have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations. During our inspection discussions with the registered manager showed that they did not have a thorough understanding around the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had concerns about the day to day management and oversight of the service. We asked to look at the service's quality assurance and governance processes. There were no robust systems in place to effectively monitor the service to ensure people's safety and mitigate risks relating to their health, safety and welfare. For example, a list provided to us on the 10 January 2017 by the quality assurance manager showed that people's care had not been reviewed. We were informed by the quality assurance manager that they had not had time to undertake a review of people's care. This meant that there were no effective systems in place to ensure that the information in service users' care plans was up to date and reflected their current needs thereby placing them at risk of receiving inappropriate care. And overall there was a lack of oversight on the registered provider's behalf regarding how the service was identifying areas for improvement and taking the appropriate actions.

A quality assurance questionnaire had been undertaken in July 2016 and records showed that, although a summary of the responses had been reported and an action plan had been developed which identified improvements which were needed to be made in different areas of the service, the action plan had not been robustly monitored by management. We spoke with the quality assurance manager regarding how the service obtained feedback from people and their families. We were informed that the service completed quality monitoring calls but we found these had not been carried out regularly and, where actions had been identified, records had not showed that these issues had been followed up. We also found that there were no systems in place to seek and act on feedback from people and communication systems were not always effective. People, care workers, families and health and social care professionals informed us that they often found it difficult to contact the service and/or the service had not returned their calls or responded to correspondence in a timely way. Information regarding people's care and support needs had not always been effectively communicated by care workers. For example, care workers had not reported issues concerning people's equipment. Conversely, where records showed that care workers had reported concerns to the office, this information had not always been followed up by management.

It was apparent from our inspection that the absence of robust quality monitoring and lack of auditing processes was a contributory factor to the failure of the registered provider to recognise breaches or any risk of breaches with regulatory requirements. The registered managers could not evidence how they were moving the service forward and the methods they used to continually improve the service people received. Additionally, people were not protected from the risks of unsafe or inappropriate care as there were no processes in place for observing staff practices and the effectiveness of staff training and support which would have enabled the registered provider to take action address the poor practices we identified. Following our inspection the registered managers informed us that as a result of our feedback they were in

the process of reviewing the systems and processes in place to ensure their audit and governance systems were safe and effective. They also informed us they had suspended taking on any additional care packages until they had recruited additional care workers.

We received mixed feedback from care workers about management. Feedback included, "I do feel valued as a member of staff and am well aware of my role and responsibilities. I do not receive regular supervisions or spot visits but always have an annual appraisal and feedback on my performance from my care manager." And, "No I don't feel valued. I feel as carers we are looked upon as skivvies. We do not get the correct attitude towards us." Records showed that regular staff meetings for care workers had not taken place. The quality assurance manager told us, and records confirmed that care worker meetings had been arranged for October 2016 but these had been poorly attended. Also care workers had not received regular supervision nor had their practice monitored on a regular basis.

People's care plans were kept in their homes and personal records held in the office were stored in locked cabinets when not in use but were accessible to staff when needed. However we found that people's personal information was being sent out by the service on a weekly basis to care workers in an unsecure format via email. This meant that the registered provider had failed to ensure that people's personal information was always kept safe and secure and managed in line with current legislation and guidance. We discussed this with the registered manager who immediately arranged for all future documentation to be sent out password protected.

The above failings demonstrated a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The service did not have effective systems and processes in place to ensure appropriate care and treatment was provided to people which reflected their current needs and personal preferences.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service was not always seeking consent from people in line with legislation and guidance.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service was not effectively assessing the risks to the health and safety of people using the service and doing all that was practicable to mitigate any such risks.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service did not have effective systems and processes in place to prevent abuse of people using the service.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The service did not have appropriate systems in place for identifying, receiving, recording, handling and responding to complaints.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not have effective systems in place to monitor the quality of the service provided because there were no audit and governance systems in place to effectively assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service and others.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service did not have sufficient numbers of suitably qualified, competent, skilled and experienced staff who were effectively deployed to meet the needs of people using the service. The service did not ensure systems were in place to sufficiently support staff in their role.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not have effective systems in place to monitor the quality of the service provided because there were no audit and governance systems in place to effectively assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others.

The enforcement action we took:

A Warning Notice was served on the registered provider