HICA

HICA Home Care - Hull

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This unannounced comprehensive inspection took place on 30 October and 02 November 2015. At the last inspection on 01 and 03 December 2014, the provider was found to be non-compliant with Regulation 12 Safe Care and Treatment of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. After the inspection, the registered provider wrote to us to say what they would do to meet legal requirements in relation to each breach.

At the time of the inspection a manager was in place. 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.

HICA Care Home – Hull is registered to provide people with care and support in their own home. At the time of the inspection there were over 400 people receiving care and support from the service.

We found the registered provider was in breach of three regulations of the Health and Social Care Act 2008

Summary of findings

[Regulated Activities] Regulations 2014. These were in relation to safe care and treatment, safeguarding people from abuse and improper treatment and good governance. We have deemed these breaches to have a moderate impact on people who used the service.

At the last inspection we found the service to be non-complaint with Regulation 12, Safe Care and Treatment of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. This was due to people experiencing missed calls and not receiving their medicines as prescribed. At this inspection we found that people continued to experience missed calls and medication errors. Two people required medical attention due to medication administration errors by care staff.

Systems used by the registered provider to assess and improve the quality of the service were ineffective. A quality monitoring programme was in place, however, it failed to ensure shortfalls in the level of service were highlighted and action was taken to improve the service as required.

People were not always safeguarded from abuse and improper treatment. Before the inspection took place we contacted by the local authority safeguarding team who told us they were investigating five incidents of poor practice. After the inspection we were informed that all five investigations had concluded and neglect or organisational abuse had been substantiated in every investigation.

Staff had completed a range of training to enable them to carry out their roles effectively. Staff received support and supervision in line with the registered provider's policy. However, when we spoke with staff they told us they did not feel supported.

There was a complaints policy and procedure and people told us they felt able to complain and raise concerns. We found that people's complaints were not always responded to in a timely way.

Staff were recruited safely and checks were completed before they commenced working within the service to ensure they had not been deemed unsuitable to work with vulnerable adults.

People had their health and social care needs assessed and personalised support plans were developed to guide staff in how to care for people. Staff were knowledgeable about people's preferences for how care and support was to be delivered and understood the need to treat people with dignity and respect during their interactions.

People's nutritional needs were met. Staff monitored people's food and fluid intake and took action when there were any concerns. People were supported to shop for food supplies and some people were assisted to prepare meals when possible.

People accessed a range of community facilities and were encouraged to maintain contact with important people in their lives.

You can see a summary of the actions we have asked the registered provider to take at the back of the full version of this report. As a result of the continued non-compliance we are considering our regulatory response and will report on any action once it is completed.

Summary of findings

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. Five safeguarding investigations were being conducted by the local authority safeguarding team at the time of the inspection. After the inspection neglect or organisational abuse was substantiated in four of the investigations and partially substantiated in the fifth.

People did not always receive their medicines prescribed. Errors by staff led to people requiring medical attention.

Staff were recruited safely including Disclosure and Barring Service checks before the commenced working within the service.

Staff had been trained to recognise the signs of potential abuse; however, people were not always safeguarded from abuse and avoidable harm.

Is the service effective?

Requires improvement

The service was not always effective. Staff had completed a range of training pertinent to their role.

Although staff received one to one support in line with the registered provider's supervision policy; staff told us they did not feel supported in their role.

People were encouraged to eat healthily and staff. People's food and fluid intake was recorded when required.

Is the service caring?

Requires improvement

The service was not always caring. In emergency situations staff did not always act in a caring way.

Staff were aware of people's preferences, life histories and understood the importance of treating people with dignity and respect.

People who used the service told us they thought they staff who supported them were kind and caring.

Is the service responsive?

Requires improvement

The service was not always responsive. A complaints policy was in place at the time of our inspection but people's complaints were not always answered in a timely way.

Reviews of people's care and treatment took place periodically. People and their relatives contributed to the planning and on-going delivery of care when possible.

Summary of findings

Is the service well-led?

The service was not well-led. Quality assurance systems used by the registered provider were ineffective. Effective action was not taken to reduce or mitigate known risks.

Action plans developed by the service to reduce medication errors were not completed or reviewed appropriately.

A registered manager was in post who understood their responsibilities to report accidents, incidents and other notifiable events.

Inadequate

HICA Home Care - Hull

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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 30 October and 2 November 2015 and was unannounced. The inspection team consisted of one adult social care inspector.

Prior to our inspection we had not asked the registered provider to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. Therefore, we looked at the notifications received and reviewed the intelligence the Commission held to help inform us about the level of risk for this service. We reviewed all of this information to help us to make a judgement. We also spoke with the local authority safeguarding and commissioning teams to gain their views on the service.

During the inspection we observed how staff interacted with people who used the service. We spoke with one person who used the service and three people's relatives. We spoke with the registered manager and three care support workers. We also received information from a social worker who visited the service.

We looked at seven care files which belonged to people who used the service. We also looked at other important documentation relating to the people who used the service such as their initial assessments, reviews and medication administration records (MARs).

We looked at a selection of documentation relating to the management and running of the service. These included five staff recruitment files, training records, staff rotas, staff meeting minutes, monthly management and compliance quality monitoring audits, audits and the results of surveys.

Inadequate

Is the service safe?

Our findings

At our comprehensive inspection of HICA Home Care – Hull on 01 and 03 December 2014, we found that people were not receiving their medicines as prescribed; this was a beach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following the comprehensive inspection we asked the registered provider to take action with regards to the safe handling and administration of medicines. The registered provider sent us an action plan that outlined what actions they would take to resolve the issues that were highlighted during the inspection.

During this inspection we found that the service had failed to implement the action plan; the registered provider's action plan stated all 'new employees will undergo all initial medication training and will subsequently undertake a minimum of three medication competency checks', 'Existing staff will undergo a minimum of one medication competency check' and a call monitoring system would be introduced to reduce the number of late or missed calls which would subsequently reduce the number of missed or late administration of medicines.

Although the call monitoring system was in place at the time of this inspection we found evidence confirming that issues with people receiving the medicines as and when prescribed continued. The registered manager told us, "The system has not been as effective as we had hoped but our regional director is looking at a new system that we are confident will be [effective]." Records we saw showed that a high number of care staff had not received a 'medication competency check' and that a number of new employees had not received three 'medication competency checks'. The registered manager told us, "It was difficult rolling out the medication competencies; we haven't done them for all the staff or the new starters. Some of the supervisors couldn't do them so we had to let them go."

People who used the service did not always receive their medicines as prescribed. Due to errors that occurred when medicines were being administered three people were overdosed, which led to support and examinations from paramedics being required and an admission to hospital. A relative we spoke with said, "We had issues with them [members of care staff] not turning up on time or not at all. She [the person who used the service] needs to have her medication at set intervals and that didn't always happen because they were not here when they should have been." Another relative told us, "The carers couldn't understand the [Medication Administration Records] MARs; that is what led to the errors and Mum being overdosed. It isn't good enough to send staff who don't have the skills to do their job properly."

We reviewed 15 MARs during our inspection and found that 13 contained a minimum of one recording error; two had five errors. The registered manager told us, "The quality assurance manager reviews a selection [10%] of MARs. Any gaps or issues she will speak to the staff and discuss the errors." We looked at 14 of the reviews completed by the quality assurance manager. We saw that after each review the recommendation [of the quality assurance manager] was that the member of care staff needed to be retrained. When internal auditing processes highlighted the continuing issue with the recording and administration of medicines the registered provider still failed to ensure regular 'medication competency checks' were carried out as outlined in their action plan.

The registered manager told us, "It is the staff's responsibility to re-order people's medicines, but we have had issues in the past when staff experienced difficulties with the pharmacy or GP. There have been times when people have not had the medication they need because of this." Failing to ensure people receive their medicines as prescribed can lead to a deterioration in the health and well-being.

The above findings represent a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently reviewing our regulatory response and will report on our action once it has concluded.

When we asked people who used the service if they felt safe, we received mixed responses. One person told us, "I never know who will turn up, I see new faces all the time and I don't like that. I don't know who these people are who come into my home, they could be anyone." We also received positive comments and were told, "I am very safe, I trust my carer implicitly", "I know she [the member of care staff] is coming every day so if anything does happen I know she will be here to help me", "All the staff are very good, I have no concerns who comes [to provide care and support] I know I am safe" and "Knowing I'm not alone; that someone will come round every day to help me with whatever I need makes me feel safe."

Inadequate

Is the service safe?

We saw records that confirmed staff had completed training in relation to the safeguarding of vulnerable audits. During conversations staff were knowledgeable about the different types of abuse that may occur; they described the signs and indications that they would look out for and what action they would take if they suspected abuse had occurred. One member of staff said, "I would report anything to the office and my manager and make sure something was done." Another member of staff told us, "I always tell the office about everything; even if it seems small it might add to a bigger picture."

However, appropriate action was not always taken to ensure the safety of people who used the service. For example, when staff became aware that a person had been given an overdose of their prescribed medicines, action was taken to report the incident to the office and seek medical attention but advice from the 111 service was not followed and the person was left alone when they needed to be observed to ensure their condition did not deteriorate. A relative we spoke with told us, "I got a call from the office to say Mum had been given an overdose and I had to go to Mum's house. When I turned up she was alone, I couldn't believe they had left her. I guess staff had recognised their mistake and some action had been taken [advice and guidance was sought from the emergency service 111 and had been recorded in the person's care file] but Mum needed to be observed in case she deteriorated and they just left her and went to the next call."

Before the inspection took place we were contacted by the local authority safeguarding team who informed us they were investigating five incidents regarding HICA Home Care – Hull. All five were allegations of neglect and/or organisational abuse; the incidents are predominately focused around, missed calls and medication errors. After the inspection we were informed that abuse or organisational abuse was partially substantiated or substantiated in all five investigations.

One person had two pain relief patches applied instead of one which led to them being physically sick for an extended period. Due to the administration error they required medical attention and were admitted to hospital. A second person had their medicines administered incorrectly which amounted to an overdose. The member of staff who noticed the error called 111 and gained medical advice, which included; observing the person for signs of sickness, shortness of breath, shaky legs and palpitations. A family member was informed by the service of the overdose and went to see the person; when they arrived the person who used the service had been left alone with only their spouse who was on end of life care and could not complete the required observations. A third service user had their medicines administered incorrectly which amounted to an overdose. Their relative noticed they were unwell and immediately called for medical support and attention; paramedics visited the person to take blood samples and observe their general well-being in case the deteriorated and required admitting to hospital. A fourth service user experienced, missed calls occurred on 21 August, 2 September and 1 October 2015. On 1 October 2015 the person's visiting relatives found them in complete darkness; they were cold, uncovered and had not received support to eat, drink, or use the toilet for over eight hours. A visiting professional reported their concerns to the local authority safeguarding team with regards to the illegal moving and transferring of a fifth service user by HICA Home Care – Hull staff.

The above findings represent a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have asked the registered provider to take at the end of this report.

We looked at five staff files and saw staff were recruited safely. Before prospective staff were offered a role within the service suitable checks were carried out to ensure they were suitable to work with vulnerable people. The registered manager told us, "Everyone has a telephone interview to check they are suitable for a full interview. Interview questions are scored, we then get two references and do a DBS [disclosure and barring service] check." We saw evidence to confirm this.

The registered manager described how they ensured the service had suitable numbers of staff deployed to meet the assessed needs of the people who used the service. They said, "We have four service co-ordinators who manage all the calls, they know what calls are cancelled or have been missed and arrange for all of them to be covered" and went on to say, "Any staff doing 50 hours in a week has to be signed off by a manager so we can ensure the care we provide is always at a certain standard. If we need staff to do that many hours we will look at recruiting [more staff]." However, Staff we spoke with told us, "When the office rings and they want calls covering we can't really say no, they

Inadequate

Is the service safe?

just keep asking until we say yes", "There is pressure when we get calls from the office [to cover calls] we can't really say no" and "The office staff try and push us to do extra calls and sometimes it's just not practical."

Policies were in place to deal with emergencies situations including the loss of staff, floods and other adverse weather conditions. The registered manager explained, "We have a continuity plan which we would follow, we would identify our most vulnerable service users, look at the two carer calls and contact families to see if they can assist. We have a list of staff who can cover calls in remote areas so we know what action we would need to take." A service co-ordinator said, "We have to make decisions about swapping carers and look at how we will get all the calls covered because that is the important thing." This helped to provide assurance people who used the service would continue to receive the care and support they required during and after a foreseeable emergency.

When the service completed the initial assessment of people's needs; a 'property' risk assessment was also undertaken. The risk assessment ensured staff were aware of the known risks with people's homes and provided guidance for staff to follow to minimise or mitigate the risk effectively. The registered manager commented, "When people's needs change or when they come out of hospital for instance we update the assessment to ensure people are safe and any hazards are removed." The quality assurance manager said, "It [the property risk assessment] has to evolve because something that wasn't an issue last week could be a trip hazard or cause people difficulties as their needs change."

Requires improvement

Is the service effective?

Our findings

When we asked people who used the service if they were supported by staff who knew how to carry out their roles effectively we were told; "They [the care staff] know me, they know my needs are they look at me really well. They all know what they are doing", "The carers are great, they do a smashing job", "My carer is excellent in every way; she is wonderful; marvellous. I have had lots of carers; they are different characters but all wonderful and talented in their own way" and "I am extremely fortunate my carer is excellent; she really knows her stuff."

Relatives we spoke with said, "Mum does get good care from her regular carers, they do a good job", "They [the care staff] know mums needs and do a really good job when they are there" and "Mum's main carers are excellent. I can't fault them."

In contrast we were also told, "The carers are lovely people, but I don't think they are trained properly" and "The carers are caring, but they don't know what they are doing half the time and end up asking mum what support she needs which shows they need more training."

Staff were supported during one to one meetings and supervisions in line with the registered provider's policy. The regional director told us, "Our policy is that staff receive four supervisions a year, which can also include group supervisions." We saw that when supervision and support was offered a number of key topics were discussed including care practice, punctuality, service user involvement during calls, respect for people's property, person centred care, medicine administration and moving and transferring practice.

We asked care staff if they felt supported in their role. Comments included, "The best support I receive is from my National Vocational Qualification assessor", "I don't feel supported", "We need more support and the communication needs to improve", "I had my last supervision two months ago, but hadn't had one for six months before that", "We are supposed to have spot checks but I have only ever had one, they don't happen like they are supposed to" and "Sometimes I feel supported, sometimes I feel like I'm out there on my own." Staff were not provided with effective support and a forum to discuss their concerns or an opportunity for learning and development to take place.

We looked at the records of team meetings and noted that for some meetings attendance was poor. The registered manager acknowledged that some meetings had higher attendance than others. A member of staff told us, "I think I have only been to one patch meeting since I started." Another member of staff said, "There was a meeting organised recently but that got cancelled."

We recommend that the registered provider seeks guidance from a reputable source in relation to providing effective supervision and mentoring to staff.

Staff had completed a range of training to enable them to carry out their roles effectively. The training records we saw included; safeguarding vulnerable adults, reporting and whistleblowing, confidentiality, person centred care, communication, privacy and dignity, nutrition, hydration, dehydration and food, infection control, health and safety moving and handling, medication and technical care skills. We spoke with the registered provider's training manager who explained, "All staff complete the training and shadow experienced staff before they work independently."

There were plans in place to develop the knowledge and skills of the care staff team. The registered manager explained, "New staff will work towards the care certificate [a recognised qualification in the care industry]" and "Our training is a rolling programme so staff are continually developing their knowledge and skills." We saw there was information held within the service which staff could refer to in relation to specific conditions such as muscular dystrophy, stroke awareness, Parkinson's and eating well.

We saw that people's capacity had been assessed and documented in their local authority commissioning service along with their next of kin, advocate or information regarding their appointed power of attorney. The registered manager informed us, "We are advising families to look gaining authorisation from the court of protection so they can make decisions for their relatives [the people who used the service] when they lose capacity."

People who used the service told us staff gained their consent before care, treatment and support was provided. Care staff we spoke with said, "I always get consent before I do anything, it's not difficult is it, you just ask people if they

Requires improvement

Is the service effective?

want you to do it [provide support with personal care] and respect their answer." Another member of care staff commented, "Our job is to support and encourage people, if they don't want to do something we can't force them."

We saw care staff had completed nutrition, hydration, dehydration and food training. Care staff told us how they supported people to maintain a balanced diet, comments included, "You get to know the people you support and what they like, we always try and encourage people to eat healthily", "I see one lady who has a very different culture and eats very differently, I love cooking for her she eats lovely home cooked food every day", "We have to record what some people eat and drink and to make sure they are getting what they need" and "Some people say they are not hungry, that they don't want anything; but I always make them something and leave it on the side, they usually eat it and just don't want us to make a fuss." Staff recognised the importance of ensuring people ate healthily and how this could have a positive impact on their overall well-being.

People were supported to see healthcare professionals when required. The deputy manager explained, "Our staff see people on a daily basis so they can spot changes in people's mood or health. When there are concerns they get passed to the office so contact can be made with people's next of kin, or relevant professionals like social workers, dieticians, the falls team, speech and language therapists or GPs." The registered manager told us, "We can look at what professionals are involved or make suggestions to social services so they can decide what needs to be done like a visit from a doctor or increased calls if someone just needs more support." This helped to ensure people's holistic healthcare needs were met effectively.

Requires improvement

Is the service caring?

Our findings

During emergency situations staff did not always act in a caring way. For example, when a member of care staff became aware that a person had been given an overdose of their prescribed medicine, they contacted the office and the emergency 111 service. Even though they were informed the person needed to monitored in case they deteriorated they left the person before a family member arrived. A relative we spoke with told us about a complaint they had made, they said, "We have had issues and that's ok I can accept that things go wrong sometimes but it wasn't dealt with properly, we got passed from one person to another and in the end got a half-hearted apology, it's like no one really cared."

When we asked people who used the service if they thought the staff who supported them where kind and caring we received lots of very positive comments. Including, "I went through a very difficult time early this year and if my carer wasn't as thoughtful and supportive and as kind as she is I wouldn't have got through it", "I have had the same carer for over two years, they have become very important to me on a personal level", "My carers are absolutely spot on", "The girls that come are great, I always look forward to seeing there smiling faces" and "The carers are always lovely."

Relatives we spoke with said, "Mum's carers are all you could hope for, they always cheer Mum up she looks forward to them coming", "They go above and beyond the call of duty to look after Mum, they are so kind" and "The carers who came were very good, very caring."

The members of care staff we spoke with had a clear knowledge of the people they supported. They knew people's life histories, where people grew up, the schools they attended and jobs they had. One member of staff told us, "[Name of person who used the service] loves to talk about her grandchildren, she has six and once she starts she won't stop talking" and went on to say, "It's amazing how the people become part of your life." Another member of staff said, "Anyone can go and make someone a drink and a sandwich or take them to the toilet. The job I do is about providing people with stimulation and keeping their spirits up so it's important to know what is important to them."

Staff understood the importance of helping people to make choices in their day to day lives and to encourage people to be independent. The care plans we saw placed an emphasis on supporting people to maintain their independent living skills when possible. A relative we spoke with explained, "I wasn't keen on the idea of home care, but Mum is doing so much more now, "The girls get her washed and dressed every day and Mum has started to be interested in her appearance again. We have noticed she is eating more and is more like her old self which we are so grateful for." A member of care staff explained, "I speak to people about what they want to eat, what they want to wear or what they fancy watching. Sometimes most of the call will be talking about a meal someone's Mum used to cook; it gets the memory going and their taste buds."

People and their relatives told us care staff treated them with dignity and respect. People's care plans contained information regarding people's preferences for how care and support was to be delivered and other important personal information such as what people liked to be called and their preferred routine. Staff described the different ways they would show people respect including, covering people over when providing personal care, closing doors and curtains when supporting people to get changed, treating people how they would want to be treated and listening to people not presuming their wants without asking.

Staff completed confidentiality training and understood their responsibility to not share or discuss people's personal and private information. A member of staff said "I take that part of my job very seriously [keeping information confidential] I wouldn't want just anyone knowing my business." The deputy manager told us, "All information is stored electronically; we all have different passwords and different levels of access so people's information is secure" and "We also have paper copies so if there are any issues with our systems we can still access important information about people's medical history or family information."

The registered manager told us that the service had utilised the local advocacy service when people who used the service required this type of support. They said, "It's usually for reviews, if people don't have the family support we will liaise with social services and commissioning to make sure they have the right support."

Requires improvement

Is the service responsive?

Our findings

People who used the service told us they contributed to their initial assessment as well as their on-going planning and delivery of care. One person said, "I am asked all sorts of questions about the carers [during review meetings] and if they do everything I need them to. My opinion is important because I'm the one getting the care." A second person said, "I told them all about what I could still do and what I needed help with; they sorted it out, it was all very efficient."

People also told us they knew how to raise any concerns about their care and treatment. Comments included, "If I needed to I would complain to the carers or ring the office", "I would call the office to discuss any problems" and "I have complained before, I have cancelled calls but the message was not passed on so the carer still arrived. I wouldn't hesitate to speak up if I wasn't happy."

The registered provider had a satisfaction and complaints policy in place that contained information in relation to response and acknowledgment times, what constituted an informal or formal complaint and what action the complainant could take if they felt the response they received was unsatisfactory. The registered manager told us, "We provide all of the complaints information to people in the welcome pack." This helped to ensure people knew how to raise their concerns and how they would be managed by the service. The deputy manager told us, "The majority of issues we have are usually about call times. People will ring up and request different times. We always try and accommodate that for them but when we explain it will probably mean they will have to have different carers people then want to stay as they are."

We saw evidence that complaints had been received by the service and that an investigation had been completed following the registered providers policy. A relative we spoke with explained, "I have complained and I have to say it wasn't handled very well. I complained in July and didn't get a response until September." Another relative told us, "I complained but nothing came of it." A third relative said, "When we have raised issues in the past; they have been dealt with which we thought was positive."

We recommend that the registered provider reviews their complaint process and ensures they manage and respond to complaints in a timely and effective way.

We saw evidence to confirm people; their family members or representatives were involved with the planning and periodical reviews regarding their care treatment and support. The registered manager explained that after an initial assessment by the social services or local authority commissioning team a care plan would be developed to meet the assessed needs of the person. Following this a representative from the service would meet with the person and their family to develop a detailed plan of care.

People's care plans contained detailed information about their preferences, likes and dislikes, daily routines, abilities, levels of independence and daily living skills. The quality assurance manager told us, "Having accurate and up to date information is critical for us to be able to deliver a high level of care" and went on to say, "When people's needs or situation changes the care plans have to be updated so we can continue to support them to be independent and remain in their own home which is usually people's main goal." The deputy manager commented, "When people come out of hospital we complete a re-assessment and make sure they get the help they need until they have recovered and can do things independently again."

People were supported to remain active and to continue to follow their hobbies and interests. HICA Home Care – Hull coffee mornings were arranged and people were encouraged to attend when possible. The deputy manager told us, "We support one person to go to a hydro pool twice a week, which they enjoy and the carers take another person to watch Hull City as often as possible."

People were encouraged to maintain contact with important people in their lives. The registered manager told us, "One man we support is a very proud and private person but with some encouragement from the carers he opened up to his family about his end of life plans, what he wanted and why. It was really beneficial for all the family and I think it brought them closer together as well."

Inadequate

Is the service well-led?

Our findings

The registered provider utilised a number of systems to assess and monitor the level of service provided; including monthly management and compliance audits, a monthly reporting system, medication administration records checks and quality assurance questionnaires. However, the systems in place were not effective and failed to ensure shortfalls in care and treatment were highlighted enabling appropriate action to be taken to prevent any future re-occurrence.

At our comprehensive inspection of the service on 01 and 03 December 2014, we found that people were not receiving their medicines as prescribed; this was a beach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. After the inspection the registered provider wrote to inform us of the actions they would take to resolve the issues that were highlighted during the inspection. During this inspection on 30 October and 2 November 2015 we found that the service had failed to implement their action plan.

Internal auditing of MARs carried out by the service's quality assurance manager highlighted the continuing issue with recording and administration errors. We saw that after each MARs was reviewed the quality assurance manager recommended the member of staff required re-training. The registered provider failed to take appropriate action to address the systemic failures regarding care staff's inability to administer and record medication safely. Individual members of care staff were retained but no wider action was taken to ensure the competencies of the entire care staff team.

At the time of the inspection the local authority safeguarding team were investigating three incidents where medication had been administered incorrectly by care staff which led to people being overdosed and requiring medical attention. One person was admitted to hospital because two pain relief patches were applied; staff failed to use body maps which would have prevented the error. The incident mirrors an incident investigated by the local authority safeguarding team in 2014. This meant that the registered provider had failed to take effective action to minimise and mitigate known areas of risk and poor performance, which directly contributed to the poor level of care received by some people who used the service. After the inspection we were informed by the local authority neglect or organisational abuse had been substantiated in all three investigations.

As part of the registered provider's action plans a call monitoring system was to be introduced to reduce and alleviate the number of missed calls that occurred. During this inspection the registered manager acknowledged the system was not as effective as they expected and missed calls continued to occur. We were told by a regional director that a new system was to be trialled in the near future. However, this demonstrated that the service was aware that missed calls could still potentially occur due to the continued use of an ineffective system.

The local authority safeguarding team were investigating an allegation of numerous missed calls at the time of our inspection. One person experienced missed calls on three separate occasions; neglect and organisational abuse was substantiated in this case. After the inspection we were contacted by a regional director who informed us that they had recently been informed of further missed calls.

The above findings represent a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently reviewing our regulatory response and will report on our action once it has concluded.

On 23 November we met with the registered provider to discuss our concerns. We were provided with assurance that the concerns found during the inspection would be rectified quickly and efficiently. We have subsequently received evidence that action has already been taken including medication competency checks being carried out on every member of care staff and the registered provider is, 'reviewing their local branch operational structure which will include a role the has medication management and training included in the role specification.' We were also told that quality assurance systems would be operated effectively to ensure information could be located in a timely way.

The registered manager understood their responsibilities to report accidents, incidents and other notifiable events that occurred within the service. The Care Quality Commission

Inadequate

Is the service well-led?

and the local authority safeguarding team had received notifications as required. We saw that the registered manager was supported by the deputy manager to ensure all incidents were reported without delay.

People who used the service confirmed they completed satisfaction surveys on a regular basis, but also informed us that they felt issues with communication within the office had not been resolved. When we asked people if they thought the service was well led we received mixed comments. One person told us, "All the issues I have are created because the office staff don't speak to each other or pass messages, if I cancel my call they thanks me for letting them know but the carer still comes because no one has told them." Another person said, "I've given feedback and they always listen, I find the office staff to be accommodating." Other people told us, "All the issues we have had been organisational. The office seems to send whoever they want and you can never get through when you ring" and "I have to say I don't like to cause a fuss but I have never had any problems really."

The registered manager told us they operated an open door policy and thought there was a transparent and open culture within the service. They also said, "I have an open door policy. I don't think it has worked as well this year because the staff bring all sorts of issues with their rotas, which wasn't the intention and is not really the place to discuss them." The deputy manager commented, "The registered manager is so supportive, I have really developed because of their support. I am doing an NVQ [Nationally recognised qualification in care] level five and never thought I would be able to something like that."

During the inspection it became apparent that information such as the numbers of branch supervisions, community supervisions, annual appraisals, patch meetings and medication administration observations could not be provided in a timely way. The registered manager confirmed, "Some of the systems we use don't make things easier it is difficult to get information quickly." After the inspection a regional director told us, "It is not an issue with the system we have it was how it was being used, information was stored in lots of different places which meant it could not be accessed quickly." Not being able to access relevant information in a timely way could lead to people being placed at risk of harm and opportunities for the service to develop being missed.

The registered provider had a clear vision and ethos for service delivery. The HICA 'SHINE' initiative is 'An aspirational philosophy that underpins our organisational commitment to continuous improvement and a personal pledge to make a difference.' The registered manager told us, "Two of our staff received a special award because they had given up their spare time on a weekend to improve a person's garden that had started to become overgrown" and "We also have good practice awards when staff have carried out their role to a high standard." This helped to ensure staff's efforts were recognised.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: People who used the service were not safeguarded from abuse and improper treatment.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People who use services were not protected against the risks associated with medicines. People experienced missed calls and did not always receive the care and support they required.

The enforcement action we took:
We are currently reviewing our regulatory response and will report on our action once it has concluded.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: People who used the service were not protected against the risks of inappropriate or unsafe care and treatment because an effective system was not in operation to enable the registered manager to assess and monitor the quality of service.

The enforcement action we took:
We are currently reviewing our regulatory response and will report on our action once it has concluded.