CareXL Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place over two days on the 20 and 23 June 2016.

CareXL is registered with the Care Quality Commission (CQC) to provide personal care to people living in their own homes. At the time of the inspection CareXL was providing care and support to 26 people.

There was not a registered manager in post however the provider had just recruited a new manager who told us that they would submit an application to CQC to become the registered manager. 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.

The service did not have systems in place to protect people from harm. Appropriate pre-employment checks and references were not sought for new staff prior to commencing their employment. Some staff had been employed with no previous skills or care experience in relation to providing care to people. People received care from staff that had not received any training or supervision to enable them to carry out their roles to meet people's needs.

Staff were unaware of their responsibilities of safeguarding vulnerable people and did not know how to report any concerns. There was no system in place for people to complain and the provider did not recognise or respond to situations where people had complained.

There were not enough staff to meet people's needs. People did not always receive the care that the service had been commissioned to provide. People did not always receive their personal care, medicines or meals as staff did not always turn up to provide their care.

There was no system in place to assess people risks or plan care to mitigate their risks. Some people did not have care plans to instruct staff on how to meet their needs, where care plans were in place they had not been reviewed for over a year. Staff were not aware of people's care needs as there were no care plans that related to their current needs.

People's medicines were not managed safely. Staff had not received training in managing people's medicines and people could not be assured that they had received all of their prescribed medicine.

Staff did not receive an adequate induction prior to delivering care and support unsupervised and did not have adequate access to ongoing supervision support or personal development. Staff did not have access to training in key areas such as moving and handling, food hygiene or medicines administration. This placed people at risk of receiving inappropriate care and support because staff did not have sufficient skills, knowledge or experience to care for people safely.

People's needs were not assessed before their care and support was delivered by staff and a number of people had no individual plans of care in place for staff to follow. This placed people at risk of receiving inconsistent care and support.

There were no quality monitoring systems in place and the provider was not aware of all of the shortfalls in the service that we have identified.

At this inspection we found the service to be in breach of eight regulations of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014 and one regulation of the Care Quality Commission (Registration) Regulations 2009. The actions we have taken are detailed 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 not safeguarded as staff were unaware of their responsibilities to protect people from harm, and did not know how to report safeguarding concerns.

Staff had not been recruited safely.

People's medicines were not managed safely.

There were not enough skilled and experienced staff employed to provide for people's needs.

Is the service effective?

Inadequate

This service was not effective.

Staff had not received training to equip them with the skills and knowledge to undertake their role effectively.

Systems to support and supervise staff were not in place. New staff did not receive an induction to support them into their role.

People were at risk of poor nutrition as there were no systems in place to assess or provide people with their nutritional needs.

There were no systems in place to ensure staff knew how to refer people to health professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

People were complimentary about the staff with comments made about their approach and attitude.

Staff were aware of the importance of promoting people's independence.

Time constraints and the lack of travel time impacted on the ability of staff to be consistently caring in their approach.

The provider did not demonstrate a caring approach to supporting people when developing rotas for staff.

Is the service responsive?

Inadequate

The service was not responsive.

People did not have their needs assessed prior to care and support being delivered.

Some people did not have a care plan in place for staff to follow.

People did not have care plans that reflected their current needs.

There was no system in place to manage complaints.

Is the service well-led?

Inadequate

The service was not well led.

People did not receive their commissioned care to meet their needs because of a systematic failure of the provider to have systems in place to assess, monitor and mitigate risks relating to their health safety and welfare.

Systems were not in place to monitor the quality of the service. Shortfalls were not being identified and addressed appropriately.

Policies and procedures were not in place or being implemented to guide staff practice and ensure that peoples received appropriate care and support.

There were no systems in place to obtain people's views and to use their feedback to make improvements to the service.

CareXL 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 20 and 23 June 2016 and was unannounced. The inspection team consisted of two Inspectors and one Inspection Manager.

Before the inspection, we looked at relevant information as to the provider's activities since their registration with the Commission. We reviewed any complaints, safeguarding concerns and intelligence provided to us about the service. We also spoke with local health and social care commissioners to gather feedback about the service.

During our inspection we met with five people who used the service and one person's relative. We spoke with seven care staff, the manager and the provider. We also attempted to contact the nominated individual for the provider.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with people, observing staff practices when we visited people in their homes, looking at documents that related to nine people's care and support. We looked at 13 records in relation to staff recruitment and training, as well as records related to the quality monitoring of the service.

Inadequate

Is the service safe?

Our findings

People were exposed to the risk of harm because appropriate checks and references had not been obtained for staff that were providing personal care and support. We reviewed 13 staff files and found that five staff did not have the required checks in place to ensure that they were suitable and safe to work with people who used the service. One staff file that we requested could not be located in the office. The Managing Director told us that they did not know where this file was. A number of staff files had no Disclosure and Barring Service (DBS) checks (these are police checks which identify if prospective staff have had a criminal record or were barred from working with children and vulnerable adults) and two staff files had copies of DBS checks completed by other organisations that showed these staff had criminal convictions. The provider had not completed any form of risk assessment or recorded any form of discussion about the relevance of these offences to the work being undertaken with vulnerable people using the service in their own home. We found numerous examples of staff without DBS checks providing care and support to people in their own homes unsupervised. The provider had not obtained references from previous employers for new staff to assure themselves that they were of good character and had the required skills, knowledge and values to be effective in their role. One member of staff told us "I was interviewed on Friday and then started work three days later on Monday. I didn't have a DBS or any references back before I started."

We reviewed the providers' recruitment and selection policy which stated "All pre-employment checks must be completed before the new employee commences employment" however; this policy was not being implemented by the provider in relation to staff recruitment. We could not be assured that the staff providing care and support to people in their own homes were fit and proper to do so. This was exposing people to unnecessary risks and we took urgent action to address this.

This is a breach of Regulation 19 of the HSCA 2008 (Regulated Activities) Regulations 2014, Fit and proper persons employed.

There were insufficient numbers of staff employed to safely provide the amount of care and support that CareXL had been commissioned to provide. The Managing Director told us that they had been "forced to deploy staff without training and DBS checks to ensure that people received their care and support because a number of staff had resigned and there were not enough staff left to deliver the amount of care and support required."

Staff told us that "Clients aren't getting up when they're meant to, people aren't having their medicines at the right time and they have their breakfast late. We're told just to go in and out. I've been asked to give care to people that require two carers on my own. I have had to; otherwise other people would miss calls." Another member of staff told us "I feel awful that I can't get to people on time. There's no travel time but I always try and stay for the length of time I'm supposed to but it means that I'm late for my next call. It's really hard."

We reviewed the rota and saw that staff were required to provide care calls to people with no allowances made for travel time between calls, records confirmed that this had led to people not receiving their care on

time. We saw examples of people having very late or missed calls and were told that this had resulted in family members having to deliver the care and support that CareXL were meant to have completed. Before the inspection we had also received notifications to inform us that people had missed calls. Care XL had not recorded these instances of missed calls however staff and the managing director were aware of them as they confirmed to us that people had received missed calls.

In conjunction with the managing director we reviewed the number of hours that care staff were available to work and provide care to people using this service. We found that there was a significant gap between the amount of care that the staff could safely provide and the level of personal care required by the people using this service. This was exposing people to unnecessary risk of not receiving the care that had been commissioned and we took urgent action to address this.

This was a breach Regulation 18 of the HSCA 2008 (Regulated Activities) Regulations 2014, Staffing.

People did not receive their medicines safely and staff did not understand their responsibilities in relation to administering people's medicines. One member of staff told us "I'm not sure about the medicine procedures here. I was told we only prompt people to take their medicines but sometimes we do assist." Another member of staff told us "People aren't getting their medicines at the right times." Staff and records confirmed that CareXL had not provided them with training in how to administer medication and that no one had ever observed them administering people's medicines to ensure that they were competent to do so.

People could not be sure that they were receiving their medicines as prescribed. We observed staff administering one person's medicines to them. Staff did not refer to the Medication Administration Records (MAR) sheets to check the medicines were prescribed. Staff removed the tablets from a person's pharmacy blister packs and gave them to the person in a plastic pot; staff did not refer to the MAR sheets to check whether any additional medicines were required that were not in the blister pack.

Where people were prescribed medicines to be taken 'when required' for symptoms such as pain there was no information recorded in their individual plans of care to guide staff as to when the medicines were needed. We observed staff administering medicines, they did not refer to the MAR sheets and did not enquire whether people required any of their 'when required' medicines. One person was prescribed paracetamol for pain; they were not offered the Paracetamol. This meant that people were at risk of not being receiving their medicines when they needed them.

People's MAR sheets were not completed consistently by staff. We reviewed the MAR sheets for three people and found that there were numerous occasions when the MAR sheet was not signed by staff to say that they had administered people's medicines. We were unable to ascertain whether these people had been administered their medicines as staff had not recorded that they had administered the medicines to them. However, for one person we could see that on three occasions they had not received their medicines because they were still present in the blister packs from the previous week. People's individual plans of care did not provide information for staff as to what prescribed medicines people had or how staff should administer these medicines.

During our visits we saw that one person was prescribed Warfarin. This medicine requires special monitoring to ensure that people's blood is not too thick which could place people at risk of significant health complications. We looked at the Warfarin records for this person and saw that staff had not recorded that they had administered this medicine on three out of the 14 days that the MAR sheet had been used for. Staff had also not consistently recorded how many tablets they had administered and had not recorded how

many Warfarin tablets had been received from the pharmacy on this person's MAR sheet. This meant that we were unable to ascertain whether this person had received their prescribed dose of Warfarin on three occasions or whether the administration of this medicine had not been recorded. We raised two safeguarding alerts in relation to the risks of people not receiving their medicines as prescribed.

There were no systems in place for the provider to assure themselves that people were receiving their medicines safely. There were no systems in place for the provider to observe staff administering people's medicines to ensure that staff were competent to do so.

This was in breach of Regulation 12(g) of the HSCA 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

There were no systems in place to protect people from harm or the risk of harm. The provider had no safeguarding procedure in place and some staff we spoke to were unfamiliar as to what they would do if they suspected harm had taken place. Staff had not received training in relation to safeguarding people and the contact details for the local safeguarding team were not readily available.

We found examples where people had not received their care due to missed care calls however; these had not been reported to the local safeguarding team. The provider told us that they were aware that some people had received missed calls. Staff also told us that other people had received missed calls. One member of staff told us "Yes, sometimes people miss calls. Sometimes things get overlooked." We saw no evidence that the cause of these missed calls had been investigated, or reported to the safeguarding team at the local authority or Care Quality Commission.

People were at risk of harm, as the provider did not ensure that staff knew how to recognise abuse or improper treatment or how to report this to the relevant authorities. We raised a safeguarding alert relating to the missed calls that people had experienced.

This was in breach of Regulation 13 (2) of the HSCA 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment.

Risks to individuals had not been assessed or steps taken to manage the risks to people associated with their care and support. Five of the 26 people supported by CareXL had no individual plans of care or risk assessment documentation in place to guide staff in their delivery of care and support or manage risks to people. Where people did have individual risk assessments completed these were not regularly reviewed to ensure that the risks to people were being managed safely.

Staff told us that they were having to "do what they thought was right" and ask people what care and support they wanted at each call because the documentation was not in place to tell them how to manage risk. We reviewed one person's care file and saw that they had a history of falls however; no falls risk assessment had been completed to identify how they could be supported to reduce their risk of falling. This person had also been identified as "not keen" to eat meals however, no nutritional risk assessment or care plan had been introduced to manage the risks associated with malnutrition. There had been a pressure sore assessment completed in August 2015 however; this had not been reviewed since it was introduced. Another person's documentation had a pressure care assessment completed in March 2015 which was documented as needing to be reviewed monthly however, had not been reviewed since September 2015. Some of the people we visited required staff to support them with moving and handling and to use equipment provided by district nurses to support people to transfer safely. None of the care files we reviewed or people we met had any form of moving and handling assessment to provide direction for staff in how to support people

with moving and handling safely. People who use the service told us that at times they had experienced rough handling by the staff who were supporting them and staff told us that they had not received training in this aspect of care provision. This was exposing people to unnecessary risk of harm.

This was in breach of Regulation 12 (2) (a) of the HSCA 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

Inadequate

Is the service effective?

Our findings

Staff providing care and support did not have the skills and knowledge that they required to care for people safely. On the first day of inspection the provider told us that no staff had received any form of training in 2016 and that there was not a training provider identified or training booked for staff. On the second day of inspection the provider told us that they had arranged training in moving and handling to take place for all staff in July however, the manager told us they did not know how staff would be released from providing care to attend this training.

One person described how they were supported with moving and handling, they told us "The male staff give me a bit of pain. Before they've even finished telling me what to do they've grabbed my arm and pulled me. This makes my leg hurt." We made a safeguarding alert about this disclosure.

Two members of staff told us "We haven't had any training with CareXL." People were placed at risk because staff without training in moving and handling were supporting people with moving and handling manoeuvres. The provider did not maintain training records for staff so we were unable to ascertain when people had last received training that was relevant to their role. We saw examples where the lack of training had impacted upon the ability of staff to provide safe care and treatment, such as medicines errors for people where staff had not received training in the safe administration of medicines. We also saw that staff without training were completing care plans and assessments for people however; the quality of these care plans was poor and did not reflect the care people needed. This meant that people were at risk of receiving inconsistent care and support.

Staff had no training, guidance or effective induction before they provided care and support to people. One member of staff told us "I had no induction when I joined. I was picked up, taken to a client once and then was asked to work on my own. I felt apprehensive after this to go out on my own." Another member of staff told us "On my first day the [provider] took me to my first house. We walked in and they showed me where the gloves and medication were. They told the person they would be having a shower and then handed over to me. There was no direction or guidance; I was left to do it."

There was no process in place for staff to receive support, supervision or to have their competency in relation to delivering care and support assessed. Two members of staff told us that "We don't have supervision but do have a lot of contact with the provider; probably every day." No member of staff had received a planned supervision in 2016. The provider confirmed that there was no process in place for supervising or checking the competency of staff.

The provider was reliant upon staff's work experience in previous employment to equip them with the skills required to provide care and support. We found that some recently employed staff had not worked in a social care setting before and that these people had not received an induction or training from the provider. These untrained, unskilled and unsupervised staff were delivering personal care to vulnerable adults. We were not satisfied that staff were sufficiently skilled, experienced, supported or had the competencies to provide care that met people's needs.

We took urgent action to address this.

This was a breach Regulation 18 (1) and (2a) of the HSCA 2008 (Regulated Activities) Regulations 2014, Staffing.

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

No member of staff employed by CareXL had undertaken training in relation to the MCA and how this affects people's capacity to make decisions and choices for themselves. There were no systems in place to ensure that people's capacity to make decisions was considered and where indicated assessed. We were aware that some people in receipt of personal care were living with dementia and therefore had limited capacity to consent to their personal care and support, however none of the care files we looked at had any form of capacity assessment completed. A number of people did not have a care plan in place however, for those who did there was no evidence to show that they had consented to their care and support.

Some staff were able to give us examples of their understating of capacity however; some staff were unsure what mental capacity was. One member of staff told us "If I had concerns about mental capacity I'd call the office." Another member of staff told us "I've never heard of that." We observed staff delivering support and saw that they did seek people's consent prior to providing care and support. We saw that staff offered people a choice as to what support they would like as well as what they would like for breakfast. However staff's lack of understanding of MCA exposed people who lacked capacity, to the risk of not having appropriate safeguards in place.

This is a breach of Regulation 11 (1) of the HSCA 2008 (Regulated Activities) Regulations 2014, Need for consent.

People who required support to eat drink or prepare their meals had not been identified by the provider. A number of people did not have care plans in place which meant staff had to ask them if they required support to eat, drink or prepare their meals. Where staff had identified that people required assistance with food and drink staff prepared a meal or snack of their choice. One person told us "The staff always ask me if I want anything to eat. My son makes my meals but the staff heat them up for me." There was no guidance for staff about people's needs such as a soft diet or allergies. Staff were unaware of people's swallowing difficulties as there had not been any assessments to establish if people were at risk of choking. This meant that people were at risk of not receiving support in relation to food and drink when they needed as staff were not always aware of people's individual support needs.

People often received their calls late as staff did not arrive at the times expected which meant that they had to wait a long time for their meals or had little time between their breakfast and lunch. On the day of inspection we saw that staff did not arrive for one person's breakfast call until 10.45 am and their lunch time call was due to be at 12.30. This person's care plan stated that their morning call should be at 8am, they told us "The carers are late; what can you do?" The records for another person demonstrated the carers did not arrive until late in the morning, this person's daughter had to support them to get out of bed, have their medicines and provide them with breakfast as the care staff had not arrived. People were at risk of not receiving food and drink regularly to maintain their health and well-being as the times that care staff visited were not regular or reliable.

This was a breach Regulation 14 (2) (b) of the HSCA 2008 (Regulated Activities) Regulations 2014, Meeting nutritional and hydration needs.

Details of people's allocated health professionals were not always available to staff which meant that they were unable to contact people's GP or health professionals for advice and support. Staff told us that if someone needed to see a health professional then they would report this to their family. During our inspection, staff contacted one person's relative to inform them that they were feeling unwell and request that they arrange a doctor's appointment for them.

This is a breach or Regulation 17 (2b) of the HSCA 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

Individual staff did what they could to form positive and caring relationships with people who use the service. However the providers approach to staffing meant that staff were at times hindered and frustrated by their inability to care for people in the way in which they deserved. We found that people at times experienced late, missed and short care calls and staff told us that time pressures meant that they could not always provide the level of care each person required.

We saw that staff had a good rapport with people and it was evident that on an individual level they treated people with compassion and respect. One person told us "The staff are nice to me; they call me their favourite man." One person told us that when they got a new mobile phone staff had shown them how to use it and programmed in the on-call telephone number for CareXL. However, staff told us that time constraints impacted upon their ability to provide a good, caring service. One member of staff told us "I often find things that haven't been done like emptying someone's bin or changing their bed. It's because we just don't have time." Staff were flexible in their approach but sometimes they were running late so the time they spent with people was compromised.

Staff tried to encourage people's independence and enable them to make choices and maintain some control over their lives where possible. However, staff could not be consistent in this approach due to the time constraints placed upon them. One person told us "the staff encourage me to have my shower myself but I know that they are just outside the door if I need them." However, staff told us that "Sometimes we're told just to go in and out and do what we have to do." We heard staff encouraging people to dress themselves in order to maintain their independence.

People were supported by staff that were caring and treated people with dignity and respect. One person told us "The carers I usually have are very good. The carers maintain my dignity; they keep me covered up with a sheet whilst they're washing one half of my body." Another person told us "My carer is great. It's like having a friend in your house. It improves my quality of life." We saw that staff closed people's curtains when delivering personal care to maintain their privacy and dignity.

We observed staff delivering care and support and saw that people were given choices about the care and support that they received on a day to day basis. People were asked what they would like for breakfast, what they would like to wear and where they would like to sit. Staff told people the weather forecast and what it was like outside to help them choose appropriate clothing for the day.

Inadequate

Is the service responsive?

Our findings

The assessment process and planning of people's care varied considerably and care files we saw were inconsistent in the content and quality of the assessments undertaken. People who were new to the service had not had an assessment of their needs completed and had no individual care plans in place. This meant that they were placed at risk of receiving inappropriate care and support because there was no direction or information for staff to follow.

The provider was aware that a number of people being supported by CareXL had no care planning documentation in place however had still accepted referrals for new packages of care. We saw that the provider had recently accepted referrals for three new packages of care and had started to deliver care and support to these people. There was no information for staff to follow in relation to call times, personal care needs, risks or healthcare needs for these people.

Other people who had received care for some time had no care plans in place. Staff told us that "if there isn't a care plan then we have to ask people and follow their instruction." The provider told us that they supported a number of people with dementia; there was a risk that these people would not have been able to direct staff to deliver their care and support and therefore may not receive care that met all of their needs. One person told us that the support they received from some staff was good however, some staff rushed made them feel uncomfortable; they did not have a care plan in place to direct staff and could not be sure they were receiving all the care they required.

Where people did have care plans in place this information had not been reviewed or updated. Care plans were not reflective of people's needs and therefore did not provide adequate direction or guidance for staff to follow in order to deliver personalised care and support. One member of staff told us that "The care plans haven't been updated, they are not accurate and we can't use them."

Care plans were not developed in a way that enabled staff to meet people's needs consistently. For example there was no guidance for staff on how to assist people who had been identified as being anxious. Care plans lacked sufficient information about people's care and support needs. They were not person centred; when they were in place they were not tailored to people's individual needs and preferences. The information within care plans did not enable staff to support people to make choices because the information was either not reflective of people's current support needs, was not there or lacked sufficient detail. There was little information about people's likes and dislikes.

Staff were delivering care and support based upon their personal perspective rather than any consistent or agreed individual plans of care. One member of staff told us "We learn what to do from shadowing other people and asking people what they want. Most people can tell us." Staff that had no training or supervision were providing care to vulnerable adults with no care plans to guide them on how to meet people's care needs. We took urgent action to address this.

This is a breach of Regulation 9(1) of the HSCA 2008 (Regulated Activities) Regulations 2014, Person Centred Care.

Procedures were not in place in order to manage and respond to complaints. The provider told us that they had not received any complaints however, one person's relative told us that CareXL had missed a call to their mother and that they had raised this with the provider. We saw that CareXL had sent a letter of apology to them and had credited their account for the missed call. This had not been logged or recorded as a complaint.

There were no records in relation to complaints available for us to review. There was no complaints procedure available for us to view or available to people using the service or their relatives. A complaints system had not been implemented by the provider. Staff told us that they would tell the provider if anyone made a complaint. Where people and their relatives had complained about missed calls they had not been logged in any way or treated as a complaint and there had been no apology made or explanation given to people or their relatives. The provider did not have any system to identify, receive, record or respond to complaints which put people at risk of receiving poor care.

The provider also told us that they were aware that some people had received missed calls. Staff also told us that people had received missed calls. One member of staff told us "Yes, sometimes people miss calls. Sometimes things get overlooked." We saw no evidence that the cause of these missed calls had been investigated, that they had been logged in any way or treated as a complaint with an apology being made to people or their relatives.

This is a breach of Regulation 16 (2) of the HSCA 2008 (Regulated Activities) Regulations 2014, Receiving and acting on complaints.

Inadequate

Is the service well-led?

Our findings

The provider was coordinating people's care and support from a location which was not registered with the commission. The provider changed location without informing CQC in March 2016. A condition of the registration for CareXL is that the regulated activity (personal care) may only be carried out from the location that is registered with the commission. We found that the regulated activity was being carried out from a location that was not registered with the commission.

This is a breach of the Care Quality Commission (Registration) Regulations 2009 (Part 4) Regulation 15, Notice of changes.

There has been a lack of stable and competent managerial oversight and leadership in this service since at least January 2016 when the last registered manager left. This has resulted in a collapse within the operational infrastructure in place and a systematic breakdown in governance and monitoring systems and processes. The provider had been overseeing the management of the service since the manager left and this inspection identified that they were failing to meet regulatory expectations across most aspects of the service provided and determined that this was exposing people to risk of harm, omissions in care and or neglect.

The provider did not have appropriate policies and procedures in place to direct staff and where they were in place we found that they were not being followed. The provider had a recruitment policy in place however, this was not being adhered to and staff were commencing their employment before the provider had obtained references and DBS checks. The provider had a medicines policy in place however, staff were not completing medication administration records and we found occasions where people had not received their medicines. The provider did not have a safeguarding policy in place to ensure that people were protected from the risk of harm.

There was no system in place to monitor the quality of the service. This meant that the provider could not be assured that people were receiving safe, effective and appropriate care and treatment. The provider had not completed any audits in areas such as risk assessments, care plans, safeguarding, training, supervision, complaints, medicines or staff recruitment files and was not aware of the significant shortfalls identified in these areas.

Staff did not have confidence in the management of the service. One member of staff told us "It's been up and down lately"; another member of staff told us "There is no organisation. It stops us from doing our job properly" and "CareXL has and does put our clients at risk."

We found that the due to staff shortages the provider was delivering care and support personally. They had no previous experience in providing care and had not undertaken any training in order to ensure that they had the skills and competencies to do this safely. Their involvement in direct care provision also meant that there was no management oversight of the service and we saw that this had impacted upon the quality of care being provided.

The provider told us that they were aware that action was required to improve the quality of the service and understood the risks involved in the current arrangements. However it was evident that they had not been able to consolidate and improve the quality of care being provided or to implement appropriate processes to assess what improvements were required. We found that there was a culture of 'firefighting' in all aspects of service delivery for example rotas were provided to staff less than 24 hours before they were due to deliver care and support and changes were being made to rotas at the last minute on a regular basis.

This is a breach of Regulation 17 (1) (2) (a) of the HSCA 2008 (Regulated Activities) Regulations 2014, Good Governance.

The service is required to have a registered manager; 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. There was no registered manager in post; however, the provider had recently employed a manager who was going to be responsible for the day to day running of the service and who was in the process of registering with CQC.

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 15 Registration Regulations 2009 Notifications – notices of change The service had moved location without appropriate notification to the CQC