Greatcare Home Health Care Services Ltd

# Great Care Home Health Care Services Limited

## Inspection report

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04 July 2017

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| 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** |

# Summary of findings

## Overall summary

This inspection took place on 26 and 28 June 2017 and 04 July 2017 and was announced. Great Care Home Health Care Services Limited is a domiciliary care service which offers support to people in their own homes.

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not always kept safe because staff practices had not always ensured security was maintained when staff visited people by ensuring doors were locked and keys kept safe. Staff had received the appropriate training so they knew how to recognise any form of abuse. However, some staff were not sure where the information should be recorded to protect a person from further harm. People did not always receive their calls as planned and systems were not effective to ensure missed calls were identified, so that people were at risk of not having their care call.

Recruitment and induction processes were in place but the necessary monitoring to ensure that staff did not work alone until all the checks had been completed was not undertaken.

Risk were not always managed effectively to ensure people were kept safe. Risks to people who were supported to take their medicines had not been identified to ensure staff supported people to take their medicine as prescribed.

People were treated with respect and dignity at all times but staff did not fully understand person centred care so that people were provided with care that met their individual needs, preferences and choices.

People's capacity to make decisions was not always assessed and the provider's systems meant that people were not consistently involved in planning their care.

Complaints were not monitored to prevent reoccurrences and records management in relation to complaints received did not evidence that they had been investigated and action taken.

Quality monitoring and audits had failed to identify that a number of areas of the service provision was not meeting the fundamental standards of care. Information provided by the registered manager was unreliable and didn't reflect the findings of this inspection.

You can see what action we told the provider to take at the back of this report.

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

The service 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. 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.

## 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 did not always have their medicine as prescribed.

Risks to people's health and wellbeing were not always managed well and people's security was not always maintained when staff left their homes.

People were safeguarded from the risk of harm because staff was able to recognise abuse but were not clear where to record information if a person made an allegation.

People were not always supported by staff that had all the required recruitment completed before they started work.

Staff were not always deployed effectively to ensure people received their call on time.

### Is the service effective?

**Requires Improvement**

The service was not responsive

Staff followed the processes of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards to ensure that people's human rights were protected.

People's health and wellbeing posed from health conditions, had not always been assessed.

Staff received supervision but wasn't always effective in ensuring that staff had the skills and knowledge required.

Training records showed that staff had received the necessary training to support people.

### Is the service caring?

**Requires Improvement**

The service was caring

People told us that staff were caring, kind and respected their privacy and maintained their dignity.

The provider had not ensured that the service was inherently caring as they had failed to ensure that people were kept safe by having robust systems in place.

## Is the service responsive?

**Requires Improvement**

The service was not responsive

People were not always involved in planning their care. Staff had some information in people's care records but this information was limited and did not show staff how to provide person centred care.

People could not be confident that their concerns would be listened to as the systems in place did not ensure that complaints were investigated.

## Is the service well-led?

**Inadequate**

The service was not well-led.

People were at risk, because risks to people's health and wellbeing were not managed effectively. Quality audits and monitoring of the service had failed to identify that people did not always received their calls as planned and appropriate action was not taken when staff were unable to make contact with people.

The registered manager had not reported allegations of abuse to the appropriate authority when allegation of abuse had been made in a timely manner, because their internal communication systems meant that this information was not shared effectively.

People did not always have their calls when planed because the systems in place did not identify areas for improvement to enable the service to improve and learn.

The cultural of the service was to seek people's views about the service they received, but the information was not always used to make improvements.

# Great Care Home Health Care Services Limited

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This inspection was prompted in part by the notification of an incident notifying us of the death of a person that was receiving a service. This incident is subject to a police investigation and as a result this inspection did not examine the circumstances surrounding the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of the service and the safety of people.

We carried out this inspection on 26 and 28 June 2017 and 04 July 2017. The provider was given one hours' notice that we would be visiting on the first day of the inspection because the location provides a domiciliary care service and we wanted to ensure that someone would be available. On the second day of the inspection we again gave the provider one hours' notice. The third day of the inspection was unannounced.

The first day of the inspection was carried out by one inspector and the other two days were carried out by two inspectors.

During our inspection we spoke with eight people who used the service six care staff, the registered manager, a person who supported the registered manager in an administrative role, two office staff, five relative, and commissioners [commissioners are the local authorities that fund people's care. We visited one person at their home. We also reviewed information we held about the service in the form of statutory notifications received from the service and any safeguarding or whistleblowing incidents, which may have occurred. A statutory notification is information about important events, which the provider is required to

send us by law.

At the time of our inspection, the service was providing support for 48 people who lived in Birmingham, Sandwell and Worcestershire. We reviewed a range of records about people's care and how the service was managed. These included care records, medicine administration record (MAR) sheets, staff training, support and employment records, and quality assurance audits that the provider used to monitor the service provided. We also looked at the information the provider had sent to us in the, Provider Information Return [PIR] this is information we request from the provider so they can tell us how the service is being managed. The PIR also gives the provider the opportunity to tell us what they are doing well and what improvements they are making to ensure an effective service is provided to meet peoples care need safety.

Inadequate

# Is the service safe?

## Our findings

The provider information return (PIR) told us, "Safeguarding is a key requirement within the Health and Social Care Act 2008 to protect and to promote the right of people who use health and social care and we believe and practice this. We have polices which relates to the safeguarding vulnerable service users minimising restrictions to enable service users to feel safe regardless of their disability or needs.'' However we found that this was not an accurate reflection of how the service was operating, and people were not protected from harm.

The registered manager told us that missed calls could only be identified during a spot check or if a person contacted them to inform them of any missed calls. There were no systems in place that enabled the registered manager to check that people unable to inform them of not getting a call had received their calls. This meant that people such as those living with dementia could be at risk of not receiving appropriate care. The registered manager told us that a new system would be installed so call could be monitored more effectively.

We found that systems did not protect people in relation to their wellbeing because people were not always receiving their calls as planned. For example, some people told us that staff did not stay for the length of time they were supposed to. One person told us that staff were meant to stay for 40 minutes but they only stayed for 15 minutes. A relative told us, "The times that staff come at each call are very close together, so [named person] has his meals too close together. He could have his breakfast at 10 a.m. then lunch at 12 p.m. and tea at 4 p.m. and nothing then till the next morning.'' They went on to say, "This then leaves a very long period of time when no one comes, about 14 hours so [named person] does not have a drink or anything to eat. [Named person] is also a diabetic. I also don't think he is safe because on a number of occasions they [staff] have left the key in the front door so anyone can get in, I have told the manager but it still happens." We visited this person and found that the key had been left in the front door. We were told by the relative that staff had left the key in the door. This showed that staff practices placed people at risk because calls were not carried out as planned and because keys were left in an external door giving potential access to the person's home to unknown people.

We found that the systems in place to ensure people were protected from harm were not followed. During our inspection we found evidence that there had been an incident that should have been raised with the local authority as a safeguarding alert and a formal notification of this to be sent to us, as required by law but had not. A representative of the organisation told us that an alert had not been raised because the staff member involved in the incident was no longer working for them and had not notified the registered manager. This showed the registered manager did not ensure that staff had a clear understanding of their safeguarding processes. The responsibilities of the registered manager to safeguard people and alert the relevant authorities would still be required even though the staff member had left the organisation. During our visit to one person, the person raised concerns with us. We reported back to the registered who was unaware of the concern and the registered manager informed the relevant authority.

Staff spoken with told us that they had completed safeguarding training and would report any concerns to

the registered manager. Although all staff were able to describe what may constitute abuse some staff said they would record this information in the person's care record at their home. This could mean the perpetrator would see the information and place the person at further risk of harm.

The provider information return told us, "Risk assessments empower people to decide if an action or activity is right for them and not only how to reduce the likelihood of harm but also how they can benefit from its experience. Our risk assessment process is divided into five parts namely: manual handling risk assessments falls prevention risk assessments, medication risk assessments, and mental health risk assessment. However we found that this statement was inaccurate and the provider's risk assessments were not robust enough to protect people from the risk of harm.

Records we looked at did not include detailed information about the risks that people were exposed to from the care and treatment they received. This would ensure staff knew how to meet their needs and what to look out for that would indicate that someone was unwell. For example, We looked at the medication administration record for one person. We saw that staff were required to support the person with their medicine which included paracetamol and an antibiotic. It was important for these medicines to be administered at regular intervals to ensure their effectiveness in resolving an infection and providing continuous pain relief.

Records looked at showed that the medicines were not being given as prescribed because staff were not attending the calls at the required times. For example, on one day the whole day's medicine was administered between 10 a.m. and 7 p.m. On another occasion one dose was administered at 10.20 a.m. and the next at 12.20 p.m. Both of these medicines should be given with a gap of between four and six hours between doses. This meant that there was a risk of a potential overdose of medicines because they were not administered as prescribed. The appropriate levels of medicines were not maintained in the blood stream to ensure an infection was appropriately treated and pain relief was not managed appropriately.

The provider's risk assessments had not identified that giving the medicines so closely together could harm the person, or identified the potential side effects of medicines. This would enable staff to be aware of what to look out for, so that this could be raised with the prescriber.

Where people were prescribed medicines on a 'when required' or 'as directed' basis for example, to manage pain relief there was no clear guidance for staff on the circumstances in which these medicines were to be used. This showed that the provider systems when monitoring and risk assessing peoples support needs in relation to planned call times, meant action could not be taken to ensure people were supported with their medicine safely. Staff told us that they had completed training in relation to supporting people with medicine. However the provider should ensure that staff are aware that a certain time gap is required between medicine dosages and where that is not possible because of current calls times then they should report this.

We saw that where risk assessment had been completed in relation to people's care there was no evidence that these risks had been discussed with the individual, or information for staff of how to minimise the risks to balance safety and effectiveness of the service provided. For example where people were diabetic, to ensure that their blood sugar is maintained.

Although staff had received training in moving and handling there was not always sufficient guidance in place to reduce these risks as far as possible and ensure people remained safe. For example, one risk assessment identified that a person had a weakness in a side of their body following a stroke the risk assessment did not give guidance to staff of how to support the person to minimise any injury.

We looked at the rotas of planned calls for staff. We saw that one member of staff was planned to attend two people at the same time. We saw that over a seven day period this occurred 12 times. For example one record showed that staff were with one person at 9.30 a.m. till 10.30 a.m. but also needed to be at the next call at 10 a.m. We saw that there was no traveling time included in the rotas to allow staff time to travel to the next call. One member of staff spoken with also felt that they were not provided with sufficient time to get to the next call and felt that staff had to rush to finish a call early, so that they could get to the next call on time. Some staff commented that they felt that there was not enough staff, to be able to attend their call when required, particular at weekends. This showed the deployment of staff was not effective to ensure that people received their call as planned.

The provider information return told us, "We have a very robust recruitment and vetting process. All applicants have to have enhanced DBS and ISA check and two references obtained before employment can commence. We have a risk assessment process for applicants that have minor offences on the DBS and this process is carried out by the manager before a decision is made. A DBS is then carried out on a yearly basis to ensure the safety of our service users. Once employed all members of staff attend mandatory training and they will have an induction period in the community with a member of our experienced support workers for a minimum of seven days.'' However we found that this was an inaccurate statement and not what we found at this inspection.

During our inspection we looked at staff files for four staff that had been recently recruited. We found not all staff had two references, not all staff had references from their previous employer to assess their suitability and conduct. We found that Disclosure Barring Service (DBS) checks were not readily available and were only produced for all staff on the third day of our inspection because of the way in which records were maintained. We asked the registered manager for the staff induction records, who they shadowed during their induction, and record of their sign off as being competent. However this information was not available. The registered manager told us this had not been recorded.

We saw evidence that staff would complete unsupervised calls without their DBS check having been received. This showed that the registered manager was not monitoring the recruitment process effectively. People spoken with told us that they felt safe with staff.  Some people told us, that it was not the same care staff all the time but they did not mind as long as they came.'' One person told us, they (staff) do what I want, only supposed to be one care staff, sometimes there is two or three come, if they are going to the next call together. Another person told us, "The staff are really nice you know, I think they do a very good job, I feel confident and very safe.''

Requires Improvement

# Is the service effective?

## Our findings

The provider information return (PIR) told us, "We work with service users to ensure they receive the best quality care and how they evaluate and evidence what we are achieving. Great Care ensures clear and regular communication is maintained between staff, service users and management to ensure a high standard of person centred care is continually maintained and we obtain consent for the care and medication we provide services users. The training of staff is reviewed and adjusted to meet the changing needs of service users."

At this inspection we found that this information was not accurate and we found that there were poor communication systems. For example, an incident that occurred before our inspection showed that clear and regular communication was not maintained with staff. There were no effective systems in place that ensured that the registered manager could monitor communications with staff and ensure that any actions needed were undertaken.

On 26 and 28 June 2017 we asked for evidence that staff had received the required training to ensure that they were able to carry out their roles. These were provided on the 5 July 2017 as the registered manager told us that these records had not been kept up to date, and our visit on the 4 July 2017 had prevent the registered manager from providing the evidence by the due date. The registered manager told us she was confident that all staff had been trained to the required standard. The poor records management meant that this information was not readily accessible to enable assessment and matching of staff with different skills to meet peoples different care needs. Staff spoken with told us that that they completed training in various different subjects so they felt that they had the skills to meet people's care needs.

The provider information return told us, "Supervisions or peer support arrangements are in place, monitored and reviewed for all staff involved in delivery of care, treatment and support to people, with their line manager or supervisor.''

Staff told us that they had supervision. Supervision is when staff meet with a senior colleague to discuss their practices, training, and personal development. Staff told us spot checks were completed. Spot checks are where a senior colleague monitors staffs practices. We saw that this exercise used a tick box method and information about discussion, training, or personal development were not included. This meant it was difficult to evidence what had been discussed which meant that the registered manager would not be able to identify if improvements in staff practices were required. We discussed our findings with the registered manager. The registered manager told us that following our inspection unannounced spot checks would be carried out on all staff members every four weeks to ensure staff were competent in their role. The forms being used will be redesigned to ensure that they are more informative.

Some staff spoken with told us on occasions that they do not feel supported by the management. One staff member told us. "I get frustrated when they don't answer the phone. I don't really know the office staff, I can call the manager if needed. I never had supervision but I have had a spot check. Some staff rush so services users are not happy. I pass this on to the manager but don't see what is done about it.'' Another staff

member told us, "I think the manager tries her best, the man in the office makes most decisions, I am not sure of his role, I feel the manager would support us if needed. It's mainly the office staff that we have contact with and the care coordinators.'' A third staff member told us, "We have training, meetings, spot checks, we can contact the office if needed where advice is given.'' Improvements that a staff member felt could be made were: "Allowing travel time between calls, progression to a senior role, better communication for example when I contact the office I don't always get a speedy reply, rotas allowing more time in between calls. Overall the management is okay and I give good care to my clients.'' People told us that they were happy with the way that staff supported them.

The Mental Capacity Act (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. We checked whether the service was working within the principles of the MCA. People spoken with confirmed that staff would ask them what they wanted doing One person told us. "They [staff] stay as long as it takes, this could be 10 minutes or 15, I am not sure how long they are supposed to stay.'' Staff spoken with told us that they were guided by the people they supported. One staff member told us "I always ask what people want, if a person has dementia I still ask them.'' Another staff member told us, we have the care plan but we still involve people, for example if they want a shower, or wash down, if they want hot meals or cold meal. I don't just go in it their home I have to respect what they want me to do.'' This showed that staff involved people in making day to day decisions which is in line with MCA.

A staff member spoken with also told us that they never asked the people who used the service to sign their time sheets, which was confirmed when we spoke with people. One person told us, "Never been asked to sign anything.'' The registered manager told us that the times staff went to people's homes were written on the call logs and, "We would know the staff had been there." However there were no records to show that this system was monitored and reviewed for the registered manager to ensure the staff had visited the person or that the staff were staying for the correct length of time allocated.

People who were supported with their meals told us that staff prepared what they wanted. Staff spoken with told us that if they had any concerns about people not eating they would report their concern to the registered manager. One staff member told us, "The family leave meals for the person and I ask which one thy want. Sometimes they just have a sandwich. I would tell the office or family if there was not enough food in the house." Another staff member said. "Some people have to have their meals early because of medication, so I try and make sure that I get there on time." People spoken with were happy with the support they had with their meals.

Staff told us in an emergency they would contact the emergency services, inform the office and wait with the person until the emergency service arrived. Staff told us that if they had concerns about a person's health they would speak with people's families or inform the office so the family could be contacted. We were not assured that the appropriate actions would be taken by staff because action had not been taken when staff allegedly reported to the office that they could not gain entry to a person home that had not had their care calls.

Requires Improvement

# Is the service caring?

## Our findings

People using the service told us that staff were kind, caring and maintained their dignity, and independence. One person told us, "They [staff] are very good and nice." A relative told us, "We're happy with the care, more than happy, they [staff] have been great, go above and beyond." One relative told us that they were often informed at the last minute that no one was available to come to support them or because the staff were late this impacted on how they were able to spend their [relative's] time whilst the staff were there. This meant that on occasions the relative had to change their plans for the day. While people told us staff were kind and caring the provider's systems and processes did not always mean people were well cared for.

People told us that staff were polite and respectful. One person told us, "He [staff] cleans up for me, he'll do anything I ask.'' He is a good carer." A relative told us, "They [staff] always cover him up whilst providing care." Staff spoken with confirmed that they would always keep people covered up whilst working from top to down and keep talking asking things like which cream or spray they [person] wanted."

Some people told us that they or their representatives had been involved in the planning of their care but not all people were aware of what staff were meant to do for them in relation to their care The registered manager had responsibility to ensure that people were fully involved in their care.

People told us that they were able to do what they could for themselves. A staff member told us that they would be patient with people who could only mobilise slowly because it was important for them to maintain as much independence as possible. People's independence was also encouraged by encouraging them to make choices about what needed to be bought for them from the shops, what they wore and what they ate.

Records seen showed little information about people as individuals. For example what their likes, dislikes and preferences were or what illnesses they had. There was a section in the record "My life before you knew me but this was not completed in the record we looked at. This meant that the systems in place did not always provide the information to support staff in the delivery of care and support people in a person centred way.

Requires Improvement

# Is the service responsive?

## Our findings

The provider information return told us, "We ensure that the assessment, planning and delivery of their care, treatment and support is centred on them as an individual and consider all aspects of their individual circumstances and their immediate and longer-term needs. Support plans are developed jointly with them, their carers and families to ensure that they reflect their needs, preferences and diversity. Together with the clients we will identify risks and agree on how they will be managed and reviewed. We will also ensure that risk assessments balance safety and effectiveness with the right of to take informed risks. We found that this was not always the case

We received mixed views from people about the quality of care they had received. One person told us, "The staff are great, I am happy with them. They go above and beyond.'' Another person said, "They come at the times we require.'' Another person told us "The staff are great.'' Some people were not always happy with their calls times and the short notice at which they were informed that staff were not available. Information shared with us by the local authority indicated that the majority of the people who used the service were happy with the care they received.

The provider information return told us, "Great Care ensures clear and regular communication is maintained between staff, service users and management to ensure a high standard of person centred care is continually maintained and we obtain consent for the care and medication we provide services users. However we found that we found that information about people's medical condition was not always recorded.

Care records are documents which are developed in relation to the care that people want and receive. Care records were not always signed by the individual where they were able to show that a discussion had taken place and clear preference and choice would be included in the delivery of care. Care plans varied in detail and nearly all required further detail to ensure that people received care and support consistently, according to their wishes and so staff promoted and developed people's independence.

One person told us, "I did not know I had to sign anything they never asked they just told me what they were going to do and that was that. They are okay though; don't have any problem with them.'' Another person told us I am not too sure what time they [staff] are supposed to come. I think they come when they like, nice staff though.'' Another person told us, "Someone came and told me what they were going to do for me.'' Some people told us that they had not had a review of their care. The registered manager told us that people care is reviewed if they carry on with the service but visited all people before they delivered their care.

Care records seen did not always contain details about each person's specific needs. For example, although people's moving and handling and dietary needs were identified the information recorded did not always give staff guidance and direction about how to provide individualised care and support that met people's needs and wishes. Not all staff understood what person centred care was. One member of staff told us that person centred care was, "Doing jobs for people.''

The provider information return told us, "All complaints are logged at head office and actioned within 48 hours of the complaint. The manager deals with each complaint personally and immediately contacts the complainant to advise that it is being dealt with. The complaint would be investigated and the outcome discussed with the complainant, this would then be discussed at a staff meeting to ensure that we as a team learn from issues that occur.'' However, we found that this was not an accurate statement.

We looked at the complaints log and saw a record that showed a missed call that had been identified by the local authority through a possible breach of contract. There was no evidence to show that the registered manager had investigated this and taken any action to minimise the risk of this reoccurring. The registered manager later told us that they had sent the required information to the local authority and had not heard back from them. This showed that the registered manager did not always follow up concerns so action could be taken.

Another person had raised a concern about the care provided. The registered manager had made a one line response on the records such as they had spoken with the staff. We asked to see the staff's personnel record and the registered manager told us that there was nothing recorded. People spoken with told us if they had concerns they would contact the office, however we cannot be assured that their concerns would be fully investigated.

We found that many of the statements made by the registered manager who was also the registered provider within their providers information return (PIR) were inaccurate. We found the safety and quality of care received was different to what the provider had told us they were providing and could not rely on the validity of the information provided to us.

Inadequate

# Is the service well-led?

## Our findings

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 registered manager in post.

We found that the registered manager was not fulfilling their legal responsibilities. For example, they had failed to ensure an appropriate safeguarding referral was raised following an incident. We identified a further incident during our visit and asked the registered manager to alert the Local Authority which the registered manager completed. The registered manager told us that they were unaware of these incidents which is why, they had not notified us, as legally required. Once she became aware then a notification was sent to us. However this demonstrates that the registered person did not have systems in place to ensure communication between staff was effective, and important information was communicated.

The registered manager had failed to ensure that there was adequate management and oversight of the service people received. The registered manager had failed to understand that delegation of tasks remained their responsibility and was accountable for any shortfalls that affected the service provision for people because checks were not completed by the registered manager. For example, we found that many of the statements made by the registered manager and the provider within their provider information return were inaccurate. We found the safety and quality of care received was different to what the provider had told us they were providing and could not rely on the validity of the information provided to us.

There was not an open and inclusive environment in the service. For example, we saw that where there had been failings the staff told us they had not been able to raise the issues with the registered manager. We saw that some senior staff were managing their area well however, there was no systems in place that enabled good practice from one area to be used to improve practices in another area. Staff spoken with told us that they had regular staff meeting to discuss the service and questionaries' were sent out to people who used the service to ask their views. However the information was not audited and analysed to identify where improvement were required.

Although the registered manager was open with us during the inspection by telling us that the systems that were there had not been used effectively to promote a positive culture for both staff and people using the service. This would not be possible if information provided was not used to improve. This showed that the registered manager did not demonstrate good leadership.

During our inspection we found there were ineffective systems and process in place to ensure that the registered manager had oversight, took responsibility, and accountability to ensure the service provided met people's individual care need, ensures risks were minimised and care was delivered to ensure people needs were met safely. For example, calls were not monitored to ensure people received their planned calls. Complaints were not investigated to prevent reoccurrences. People were not always involved in their care.

Medicine management did not always ensure that support was provided to ensure people received their medicine as prescribed. Records management meant that records were not easily accessible. For example, shadowing records and staff recruitment checks were not in place to identify that staff were suitable to work with people. Monitoring in relation to quality and safety by the provider had not identified the failing as found during our inspection. We found that people may be at risk because the registered manager does not identify risks to people nor do they take immediate action to mintage the risk to people's health and wellbeing.

We asked the registered manager how calls were scheduled and monitored. The registered manager told us that they monitored this, but was not able to show us the records in support of this. We identified that in one person's record that calls were between one hour and twenty minutes late on three occasions. The registered manager was unaware of this although she stated that the daily records were audited on a monthly basis. We asked to see the monitoring records for times of calls to people homes, to include staff rotas we were provided with the rotas of staff however the registered told us that monitoring of calls had not been recorded. This showed the providers did not have an effective system's was not being used to monitor the calls of people or identify where there was discrepancy.

We asked the registered manager how missed calls or late calls were monitored to ensure people were not placed at risk by not receiving their calls as planned. The registered manager told us that there was not an official way of monitoring them, however people could call the out of hour's service where a member of staff would be available. We asked to see the on call log, however this was not available. This showed that the registered manager would not be able to ensure action was taken in relation to the frequency of missed call or late calls and the systems and processes to monitor this were ineffective.This was Breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014. Good Governance