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Cotswold Care Unlimited

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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We undertook an announced inspection of Cotswold Care Unlimited on 28 June and 12 July 2018. Cotswold Care Unlimited is a small domiciliary care agency registered to provide personal care to older adults living in their own homes. Not everyone using Cotswold Care Unlimited receives regulated activity; CQC only inspects the service being received by people provided with 'personal care' and help with tasks related to personal hygiene and eating. Where they do we take into account any wider social care provided. On the day of our inspection, 11 people were being supported under the regulated activity of personal care.

At an inspection in October 2013, we identified that people were not protected against the risks of poor care because the provider did not have appropriate recruitment procedures in place. This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to submit an action plan to explain how and when they were going to ensure compliance. At an inspection in March 2016, we found these checks were still not always taking place. We did a focused inspection in September 2016 to follow up enforcement action regarding safe staff recruitment and quality assurance systems. At this inspection, we found the provider had not taken all the necessary actions to improve their quality assurance systems. We therefore imposed a positive condition on the provider's registration requiring them to submit a monthly action plan detailing audits of people's care plans, risk assessments and records of their care delivery with a report of action taken or be to be taken as a result of the audits. At the last comprehensive inspection in March 2017 the CQC once again asked the provider to take action to make improvements to how they audited the safety and quality of the service and to audit staffing records, including training and recruitment processes. This action had not been completed. Since the provider had registered with the CQC in 2012 they had failed to meet their regulatory responsibilities as a registered provider at each consecutive inspection.

At this inspection, the provider had still not ensured that safe recruitment practices were being followed. People's needs were not always being assessed to reflect current care needs and risk assessments were not evidencing people's current risks. This meant staff may not be able to provide safe care and support. The provider was not ensuring that care staff were safely administering medicines, correctly moving people and ensuring that staff understood the principles of the Mental Capacity Act 2005 as training had not always taken place. Not all staff were able to clearly explain how they would recognise and report abuse. Not all notifications had been made in line with the safeguarding policies. Learning from previous inspections and enforcement action had not resulted in the service improving.

Not all people had care plans in place to inform staff of their current needs. We also found that care plans were not being regularly reviewed to reflect any changes.

The provider had not developed all necessary processes and systems to ensure the quality of service provided.

People who used the service told us they felt safe with the care and support that staff provided. There were sufficient staff to meet people's needs and people received their care when they expected. People who used the service were asked to consent to the care and support provided.

People told us they benefitted from caring relationships with the staff. All people and their relatives we spoke with were positive about the care they received. People told us staff treated them with dignity and respect and supported them to make decisions about the care and support they received.

Where people had care plans, these contained person centred information about the person's preferences, likes and dislikes and personal history.

People and their relatives were aware of how to make concerns known. There had been no complaints or concerns recorded since the last inspection in March 2017.

There was evidence of staff having team meetings to discuss people's care.

There were widespread and significant shortfalls in the way the service was led with regulations not met and repeated in previous inspections.

We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also identified a breach of Regulation 15 of the Care Quality Commission (Registration) Regulations 2009

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."

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

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.

Systems, processes and practices did not ensure people would always be safeguarded from abuse.

People's risks were not always accurately assessed, monitored or managed to ensure they were up to date and records reflected this.

The provider had not ensured the proper and safe use of medicines

The provider had not ensured that people's safety was assured as they had not made improvements for a sustained period.

People who used the service told us they felt safe with the care and support staff provided. They felt there were sufficient staff to support them to keep them safe.

Is the service effective?

Inadequate

The service was not effective.

People's needs had not always been assessed and care and support was not delivered in line with current guidance to achieve effective outcomes.

The provider had not ensured that staff had the skills, knowledge and experience to deliver effective care and support.

People who used the service were asked to consent to the care and support provided.

Staff supported people who used the service to eat and drink enough and to access healthcare service where necessary.

Is the service caring?

Good

The service remained caring.

People and their relatives stated that all staff treated them with kindness, respect and compassion.

People's dignity, privacy and confidentiality was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had not always got the appropriate information in their records that reflected all their care and treatment needs.

Some care plans contained information about people's social histories and likes and dislikes.

Feedback from people who used the service demonstrated that the care and support provided was person-centred.

Complaints processes were in place and people knew who to contact if necessary.

Is the service well-led?

Inadequate

The service was not well led.

There were widespread and significant shortfalls in the way the service was led.

Regulations were continuously not met.

Delivery of good or high-quality care was not assured as there was a lack of governance in place.

Cotswold Care Unlimited

Detailed findings

Background to this inspection

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

This inspection took place on the 28 June and 12 July 2018 and was announced. The provider was given 48 hours' notice because the location provides a small domiciliary care service and the provider is often out of the office providing care. We needed to be sure someone would be in. This inspection was carried out by two inspectors.

Inspection site visit activity started on 28 June 2018 and ended on 12 July 2018. We visited the office location on both days to see the provider and care staff. We spoke with the provider, the senior team leader and four members of staff. We also reviewed five people's care files, medication administration records, seven staff files, staff rotas, meeting minutes and a selection of records used to monitor the quality of the service. We visited one person in their home to look at records and seek their views on the service. Following the inspection, we contacted three relatives to ask for their views about the service and care staff.

When planning our inspection, we looked at information we held about the service, which included information shared with the Care Quality Commission (CQC) via our public website and notifications sent to us since our last inspection of the service. A statutory notification is information about important events such as accidents and incidents in the home which the provider is required to send to us by law. We also contacted the local authority's commissioning team to ask if they had any relevant information about the service. We used this information to plan our inspection.

The provider did not meet the minimum requirement of completing the Provider Information Return at least once annually. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we made the judgements in this report.

Inadequate

Is the service safe?

Our findings

At an inspection in October 2013, we identified that people were not protected against the risks of poor care because the provider did not have appropriate recruitment procedures in place. This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds with Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to submit an action plan to explain how and when they were going to ensure compliance. At an inspection in March 2016, we found these checks were still not always taking place. We followed this up at an inspection in September 2016 and the provider had still not met this regulation. A requirement notice was issued and at the last inspection in March 2017 improvements had been made.

However, at this inspection in July 2018, we found there were not effective recruitment procedures in place to ensure staff were safe to work with adults at risk. For example, on the first day of the inspection we identified that one staff file (who had been recruited since the last inspection) had no record of a Disclosure and Barring Service check (DBS) being obtained prior to starting work. The DBS carry out criminal record and barring checks on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. This ensured that people were protected from the risks of being cared for by unsuitable characters. We asked the provider who advised us they had applied for one but it had been lost in the post. We asked for evidence that this had happened but the provider did not have any. The senior team leader advised that a new DBS had been applied for and we saw a record of a DBS application submitted on 26 June 2018 (this was after the provider had been notified of the inspection visit). From records we looked at there was evidence that the staff member had started working for the service in August 2017. The provider confirmed this staff member was working without a DBS. We found another member of staff (recruited since the last inspection) who did not have a current DBS and that once again, this had been applied for on 26 June 2018. Neither member of staff had a risk assessment identifying how the provider had assessed the staff as being safe to work alone whilst awaiting a DBS. Following the first day of the inspection the provider was asked to provide reassurance that these staff would not work unsupervised until their DBS had been received. We received assurance from the provider that they would only work on visits with other carer workers. On the second day of the inspection, we looked at staff rotas between 30 June to 12 July 2018 and found both staff members had worked alone and completed double up visits together without evidence of any supervision.

We saw in one staff file there was one reference stating the referee had known the member of staff for three years but did not state in what capacity they were known. We asked the provider about a second reference from the member of staff's previous employer. The provider said they had received a reference from the previous employer and that "It must be on my emails somewhere". The provider advised they would find the reference and provide a copy to the inspector. This was not made available on the first day of the inspection. On the second day of the inspection there was a second reference on the staff file. The reference was dated 28 June 2018 (the date of the first day of the inspection). Another member of staff had no references and the provider said she had not obtained any references as "I knew her well". These actions meant people were supported by care staff with no assurance that they had been checked to ensure they were safe to work with vulnerable adults.

These issues were a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider's systems and processes were not effective in preventing people from abuse. We saw the safeguarding policy and procedures were not up to date. The safeguarding procedures included a copy of the local authorities safeguarding policy dated September 2012. This was not an up to date copy as the policy had been reviewed and updated in August 2016 and reflected current legislation. The Cotswold Care Unlimited safeguarding policy was dated 1 April 2016 but did not reflect changes to legislation made prior to that date. The policy referred to out of date guidance documents.

The provider did not take appropriate action when they were made aware of people who may be at risk of harm. One member of staff told us they had reported some concerns raised by a person in relation to potential harm. We spoke with the provider about what action they had taken following the concerns being raised. The provider told us they had discussed it with the person's relative and said, "I don't want to jump the gun" when asked about reporting to external agencies. The provider had made no record of the incident or the contact made with the relative. The provider told us the care worker had recorded the details in the person's daily record in the home. However, the member of staff said they did not record the details in the person's daily records as other people had access to the record. The concern had not been reported to the local authority safeguarding team.

Staff had completed workbooks in "safeguarding of adults". However, staff we spoke with were not always clear about the action they should take if they felt a person had experienced or was at risk of harm. Staff comments included, "I would make notes objectively and report to the manager. I would let all the other girls (care workers) know and monitor the situation. I would phone CQC if I needed to" and "I would report to [provider] or [senior team leader] straight away. I'm not sure where I'd go; the police a doctor, yourselves?"

The provider had not ensured staff were following their policy on the Mental Capacity Act 2005 (MCA). The MCA is designed to protect and restore autonomy to people who may lack capacity to make certain decisions due to illness or disability. The provider's policy stated that Cotswold Care Unlimited would assess the client and their mental capacity when they started using the service. The policy also stated that "If a client is found to be unable to make a decision, we will need to use the decision-making form and your manager will help you with this at the appropriate time". People's care records did not include consideration of people's capacity to make decisions. One person's care record included an assessment from the funding authority which identified the person was living with advanced dementia. The assessment identified the person was being supported by health professionals in relation to their memory and had appointed a legal representative to act on the person's behalf. However, there was no care plan detailing how this person's needs would be met in relation to their memory or mental capacity and no information relating to the decisions the legal representative could make on behalf of the person. The provider told us they had not seen a copy of the legal authority.

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

People's records did not always have up to date and comprehensive information about risks and safety. For example, one person's record contained no care plan or risk assessments other than an assessment that had been sent from the local authority when commissioning care. The provider said they followed the care plan in this assessment. However, the assessment did not reflect the person's current needs. The assessment stated they did not weight bear and needed two staff to use a hoist to help them transfer. On the second day of the inspection we asked the provider about this. They informed us the person was no

longer being hoisted for transfers and was being cared for in bed. There was no information on the person's records to reflect this or any risk assessments in relation to caring for the person in bed to minimise pressure damage, such as regular turns.

A person's records contained a copy of an assessment completed by the local authority when care commenced. This stated two carers were required to assist the person onto a commode using a standing hoist. We asked the provider about this and they said the person was no longer using a standing hoist since being discharged from hospital two weeks prior to the second day of the inspection. We discussed with the provider that risk assessments had not been updated to ensure care staff were able to reduce any risks whilst the person was being hoisted. The provider agreed that the local authority assessments were no longer reflecting the person's current needs and agreed to ensure a care plan was put in place to reflect the person's current needs and associated risks.

The provider went on to say that a ceiling hoist had now been fitted and that an occupational therapist had done some training with four members of staff on the 11 July 2018. We asked a member of staff who had been named by the provider as having completed the training who said they had not had attended this training. We looked at the rota for the 12 July 2018 to see which staff had supported the person and we saw that two members of staff who had not attended the training by the occupational therapist the previous day had delivered care using the hoist on the 12 July 2018. These two members of care staff had no record of completing any moving and handling training or had been observed in practice to ensure they carried out moving and handling procedures safely. The absence of risk assessments and training meant there was a significant risk of the person coming to harm whilst being hoisted. This meant people were not always adequately protected from risks during certain procedures.

The provider was unable to provide any evidence to show that all care staff had undergone training and assessed as competent before administering medicines. It was not evident that guidance from The National Institute for Health and Care Excellence (NICE) regarding managing medicines for adults receiving social care in the community was reflected by the service's management of people's medicines. The guidance advises that social care providers should have robust processes for medicines related training and competency assessment for care workers, to ensure that they receive appropriate training and support, have the necessary knowledge and skills, assessed as competent to give the medicines support being asked of them, including assessment through direct observation and have an annual review of their knowledge, skills and competencies.

The provider told us that medication training was part of the Red Crier training (distance learning) care staff completed. However, there was no evidence that the provider had assured themselves that care staff were competent before administering medicines alone in line with NICE guidance. For example, the provider told us that one person's partner did all their medicines and staff were not involved in this part of the person's care. This was also noted on the local authority assessment on the person's records. We looked at the notes that care staff had made and saw that care staff had administered medicines. NICE guidance had not been followed as there was no assessment of the person's medicine support needs on the assessment or a care plan drawn up by the service and it was not clear who was responsible for administering the medicines. This meant we could not be sure people were receiving their medicines safely. The provider told us they always left a note for the person's partner if they had administered the medicine.

Where people were prescribed topical medicines, there was limited information about where the topical medicine should be applied, to ensure correct application by care staff. For example, we saw guidance for one prescribed topical medicine just said apply to legs. If a different member of care staff provided the care, it was uncertain they would know where on the legs to apply the topical medicine and thickness of

application. This would mean that the person may not receive their medicines as required. We discussed this with the provider and on the second day of the inspection they had introduced a more detailed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Previous inspections had found concerns in the areas identified above. The provider had submitted action plans and monthly audits. However, despite this we found minimal evidence of learning or actions being taken to improve safety. For example, a safeguarding alert had not been made following a member of staff raising concerns to the provider. The service was not complying with guidance around medicines. The service had a system to record accidents and incidents in the service. However, the service reported that no accidents or incidents had occurred since the last inspection so it was not possible to evaluate whether these were being recorded and acted upon, if they occurred.

The provider had assured inspectors after the first day of the inspection that plans would be put in place for staff who did not have a DBS to not work alone. On the second day, we found evidence that the provider had failed to do this. This was evidence of the provider not mitigating risks where people may be at risk of harm.

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

A person we spoke with who used the service told us that they felt safe with care staff and said "Absolutely safe. No doubts about that!" Feedback we gained said that people received their medicines when required. There were sufficient numbers of care staff available to meet people's needs. We observed a visit to one person and the member of staff was not rushed in their duties and had time to make a cup of tea for the person and their spouse and have a chat before they left. A person we visited told us that care staff turned up at the appointed time most of the time but said if not, it was always because someone was unwell and needed support for a bit longer, which they understood. They would be notified if the visit was delayed. Of those we sought feedback from, nobody raised concerns about the timing of the visits or missed visits.

The service had a list of priority of visits if there was, for example, a severe weather situation which impacted upon delivery of care. This meant people were assured of receiving care if they were particularly vulnerable and there was no-one else to step in for a short period of time.

People were protected against the risk of the spread of infection. Care staff were provided with aprons and gloves and we saw these being used on the day. Environmental risk assessments in people's homes had been completed to help care staff to identify and minimise risks whilst working in someone's home.

Inadequate

Is the service effective?

Our findings

At an inspection in March 2016, we found care staff had not always received the appropriate training to ensure care was delivered effectively to people in line with their care needs. This was a breach of Regulation 18 of the Health and Social Care Act Regulations 2014. At an inspection in March 2017, we found that the requirements were still not being met as care staff had still not undergone the necessary training prior to supporting people. We imposed a condition to ask the provider to submit monthly audits to update the CQC on staff training. These audits had not always been submitted when required and when evaluating these audits at this inspection we found the audits were not effective in evidencing that staff were fully trained in areas to support people, such as moving and handling and awareness of the Mental Capacity Act 2005.

At this inspection, the provider had still not assured themselves that staff had the appropriate training to meet people's needs. We saw that people who needed to be assisted to move via a hoist were supported by staff that had not had the training to do so safely. Not all staff had completed face to face training in moving and handling. One member of staff said, "I did not have any (face to face) training, I just did it with the girls [other staff]." The provider's moving and handling policy stated, "Every employee of Cotswold Care Unlimited is required to attend an induction course which includes information, instruction and training in the correct methods to be followed when moving and handling objects and people".

The provider had a limited induction system in place for new staff to ensure that staff were prepared to undertake their roles and responsibilities. For example, we asked the provider about a recent member of staff's induction and training. The provider told us, "[Name of care staff] did two weeks shadowing with me before she started". We asked the provider if the member of staff had any formal training. The member of staff had started working for the provider four months prior to the inspection. The provider said, "No nothing formal. She won't have had any because she's just started, but she should have done a batch (referring to the training workbooks)". The staff's name was not on the monthly audits provided to CQC about staff training. The latest audit had been received on 15 June 2018. We were told by the staff member in charge of training that this member of staff had completed a workbook in "Safeguarding of adults" which had been sent for assessment. There was no other evidence to show that the provider had ensured the staff member had other skills and knowledge necessary to meet people's needs. We saw on the rotas that this member of staff was assisting people with medicines and hoisting. The provider had not assured themselves that the member of staff had the competence to do this safely by providing training or observation of the tasks. After the first day of the inspection, the provider informed us they had developed an induction procedure.

The provider used a workbook assessment form of training which were then submitted to the training provider to assess. We saw that care staff completed workbooks on a range of topics including: safeguarding, dementia awareness and safe handling of medicines. We asked for, but received no evidence that there were systems in place to monitor staff's competence in specific areas, such as administering medicines, to ensure they had the skills and knowledge to safely meet people's needs.

We reviewed whether the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the

mental capacity to do so for themselves. The MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make 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. The provider was not able to provide evidence that all staff had received training in the Mental Capacity Act 2005 and on discussion with staff, we found they did not understand the principles of the Act and how this would impact on their role. There was one person being supported who had advanced dementia. Staff would therefore be required to know how to ensure they were working to the principles of the Act to ensure the person's capacity to consent was assessed in specific decisions. Staff comments included, "I've not had any training but we're not supporting anyone who has no capacity. We would speak to family first. See what the family wanted to do. If they had no family then (provider) would have to make a decision"; "MCA is included in our other training. We would gauge them, their capacity to take their medicines. Shall we give it to them on a spoon?"; "We try to encourage. We can only ask them three times or it's abuse" and "We only ask three times as then it's harassment".

We asked the provider about whether any unannounced checks took place whilst staff were delivering care in people's homes (spot checks). We were informed that a senior member of staff undertook spot checks. However, there were no records of these and therefore no record of staff competencies being assessed. The provider said, "I would have checked her (staff member) competence when I was with her shadowing. I don't record that". A member of staff said, "My previous supervisor did checks but she left a couple of months ago. Don't know who does them now".

These issues are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not developed robust systems to assess, monitor and improve the quality and safety of the service provided. For example, not all people had their support needs and choices assessed by the provider prior to receiving support. We saw that people's whose care was funded by the Local Authority or the Clinical Commissioning Group (CCG) had a copy of a Functional Analysis of Care Environments (FACE) assessment in their records. A FACE assessment is completed by Local Authorities who have a duty under The Care Act 2014 to assess people's needs and their eligibility for publicly funded care and support. These assessments are often shared with providers of care to further develop a care plan of how their service will meet these needs. For example, it would state what support a person is getting on an ongoing basis from family, friends or volunteers, including support for taking medicines. We noted that for one individual their needs had changed since the FACE assessment and information had not been updated to reflect this to care staff. This meant that the initial assessment was being used to deliver care which had become out of date and this was not reflected in any other records. People who were self-funded were visited by the provider and senior care worker to gather their needs prior to being supported. We asked for, but did not see, what the initial assessment included to inform a care plan. Due to the small number of people supported and small staff team the lack of systems did not negatively impact on people's care as care staff knew people's needs well which reduced the risks.

These issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the provider about how support was provided to care staff in their roles. We were told that all staff had been issued with work mobiles to enable effective communication. Most staff told us they felt supported in their role with comments such as, "I have one to ones with (provider). I've had one or two supervisions" and "I think I'm supported to provide care and to build my confidence".

We asked for feedback about whether consent was always sought and all we spoke with said staff always asked for permission before any tasks were carried out and had never experienced care staff undertaking any care without this consent.

Where people needed support with having meals prepared, this was recorded. Care staff told us people decided what they wanted to eat and drink and they cooked meals and served them. Staff documented in people's daily notes what support they had provided and recorded what people had eaten or had to drink during their visit. This enabled care staff to monitor people's food and fluid intake to identify any issues or concerns around dehydration or malnutrition.

People's care files contained information about their medical history and any on-going health needs. Care files also recorded contact details of any healthcare professionals involved in supporting people who used the service. This was important as it meant care staff had information about who to contact in the event of an emergency. All those we asked for feedback from confirmed that care staff supported them or their relatives to maintain good health. Comments included, "I can contact the GP for my relative so don't need them to do this for me. No doubt they would if needed."

Good

Is the service caring?

Our findings

Despite finding longstanding and widespread concerns about the way the service was managed; people told us that on an individual basis the care staff that supported them were kind, caring and compassionate.

The small care team meant people received support from familiar staff who knew them well and understood their needs. Staff had the time to get to know people and understand their care and support needs, wishes, choices and any associated risks. the service, people and their relatives spoke very positively about staff. We heard staff ensured that people were treated with kindness. Those we contacted spoke consistently highly of the kindness, compassion and respect from care staff. A relative told us, "I'm thrilled to bits. Don't know what I'd do without them. Can't fault them in any way, shape or form". Another said, "They are very good and very kind. No concerns".

Care staff spoke with kindness and respect when speaking about people. They enjoyed their job and were enthusiastic about providing good quality care. A member of staff said, "I love this job. Wish I'd done it years ago." All the staff we spoke with showed a commitment to provide the highest quality of care and spoke of their enjoyment of helping people to live comfortably.

Staff took action when people were in discomfort. For example, we saw one person was experiencing skin pressure problems and we saw that the staff had contacted the district nurse and GP to ensure the person had the appropriate input as necessary. We spoke with a family member who said, "Every time [name] has been taken to hospital they've (care staff) stayed with [person] till the ambulance has come". Another family member explained as well as their relative receiving support from staff, they also felt supported. One relative said, "Superb. They not only care for [person] but care for me too. They help me change my quilt cover which I struggle with".

People were treated with dignity and had their privacy respected. For example, a person we visited said staff always took them into their bedroom to have their personal care done. We observed on this visit a member of staff checking the person and their spouse were comfortable and happy before leaving, making them both a cup of tea and having light hearted banter. A relative told us, "They chat to [name] all the time explaining what they are going to do and when they have done it".

Staff were discreet and respected people's confidentiality. We saw that records containing people's personal information were kept securely.

Requires Improvement

Is the service responsive?

Our findings

At an inspection in March 2016, people's care plans did not always have all the relevant and up to date information to ensure people's care was delivered in accordance with their needs. There was limited evidence that people were involved in developing and reviewing their care and support. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to send a report stating what action they were going to take. At the last inspection, we found information was incorporated in the care plans about people's background, families and social history. This assisted staff to have a holistic view of the person they were supporting, not just their care needs.

At this inspection, although we found care staff knew people well and were providing person centred care, the records were not always complete, up to date and accurate. Not all people's records contained a care plan developed specifically for the provider's responsibilities. Where people had been assessed and referred to the service by the local authority there were no care plans to detail how people's care needs would be met. One person's records had a FACE Overview Assessment completed by the funding authority prior to commencing the service. A FACE assessment is completed by Local Authorities who have a duty under The Care Act 2014 to assess people's needs and their eligibility for publicly funded care and support. These assessments are often shared with providers of care to further develop a care plan of how their service will meet these needs. There was no care plan in the person's care plan advising staff on how the person's needs should be met. We asked the provider who said, 'We work from the FACE assessment for funded clients." The provider said that care plans were in place for people who had not had an assessment completed by the Local Authority.

One member of staff told us they had visited a person who's needs had changed significantly in relation to medicine administration since they had last visited them several weeks before. The member of staff said, "The care plan for creams had not been updated. I had to call [senior team leader] as I didn't know what creams went where as they had changed a lot". The member of staff told us, "There isn't always up to date information. If they're social services [funded] they [care plans] don't get reviewed very often". Therefore, people may not always receive care that met their needs or was personalised to them.

The provider was not always aware of the people the service was supporting. The senior team leader told us they had recently started supporting a person with personal care once a week. They said the person had been visited three times. We asked the provider for the person's care record and assessment. The provider told us, "I don't have the assessment. We're not doing [person] anymore". We advised the provider that the senior team leader had visited the person three times. The provider was unable to provide an assessment of the person's needs or a care plan detailing how the person's needs would be met.

People care needs had not been reviewed. For example, one person's care plans had been developed in May 2016. The provider was unable to supply any evidence to show that the care plan had been reviewed since that time. Care records should be regularly reviewed to ensure any changes in people's needs are identified and recorded to enable staff to care for people safely. This meant that the provider had not maintained an accurate record in respect of each person using the service. This included a record of care and treatment

and decisions taken in relation to the care and treatment provided.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw that there were systems in place to share information between different care staff visiting. Staff wrote daily notes kept in a folder in people's homes. This recorded detail of the care and support provided at each visit, including the time and length of calls, the support provided and any issues or concerns identified. This helped to ensure that information was handed over to the next member of care staff visiting that person.

The provider had established a system to manage and respond to complaints and concerns. The provider told us no complaints had been received. We were told that people were given information about how to raise concerns or complaints. One person told us, "No complaints whatsoever". Those we contacted for feedback reported no concerns and said they knew who to contact if they had any. The provider also provided 'hands on' care and support and saw most people on a regular occasion.

The provider informed us that they were not currently supporting anyone with end of life care.

Inadequate

Is the service well-led?

Our findings

At an inspection in March 2016, we found the provider had failed to establish and operate effective systems or processes to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was a breach of Regulation 17. We took enforcement action, issuing a warning notice advising the provider they must make improvements to meet the legal requirements by 17 June 2016. We followed this up in September 2016, and found the provider had still not established systems to assess monitor and improve the quality of the service. We therefore imposed a positive condition on the provider's registration with the CQC to submit a monthly action plan detailing audits of people's care plans, risk assessments and records of their care delivery with a report of action taken or be to be taken as a result of the audits.

At the last inspection in March 2017, we found that quality assurance systems were still ineffective as they had not identified an accurate overview of whether the service was meeting the fundamental standards. We therefore varied the condition imposed at the September 2016 inspection asking the provider to incorporate audits of staff records including training. This was alongside continuing to send audits of care plans and risk assessments to ensure the regulation was being met. The purpose of this was to provide evidence that the provider was evaluating the service to ensure improvements were made where necessary. However, the CQC did not receive audits for every month and the provider had to be contacted on some occasions to follow up where these were.

During this inspection in July 2018, we found the audits submitted were not effective. We received the latest audit on 15 June 2018 after contacting the provider to say it had not been submitted as expected at the end of May 2018. These audits included checking staff records so action could be taken if needed. However, on the day of the inspection we saw that a member of staff had been recruited in March 2018 and had not been included in the audits submitted in April or June 2018. We found this staff member did not have a current DBS. We saw another member of staff who appeared on the audit received from September 2017 onwards as awaiting a DBS. This had still not been received at the time of this inspection. This meant the person had been employed without a DBS in place for nine months and the auditing had not been effective in ensuring the quality of the service was improved with monitoring and evaluation of process and systems. Therefore, action had not been taken where needed.

Both this and previous inspections identified ongoing and widespread, significant shortfalls of how the service was led. The provider had not reviewed the delivery of care and support against current guidance as reported in the Safe and Effective domains of this report. This meant high-quality care of the service was not assured. The CQC asked for actions following previous inspections to encourage the provider to make the necessary improvements and sustain these to ensure the service was safe. During this time, risks to people were mitigated due to the small size of the service with consistent staff who knew people well.

Neither the provider or senior team leader had a clear view of what each of their roles, responsibilities and accountability was. For example, during the inspection we asked the provider questions and they were unable to provide accurate information about the status of staff recruitment or staff training deferring to the

senior team leader. The provider did not understand the principles of good quality assurance to drive improvement as there was little evidence of learning, reflection from previous inspections and their findings to implement and sustain service improvement. Any actions taken had been reactive to findings on the inspection rather than having a proactive approach and overview of actions to implement improvements.

We saw a training and supervision policy which stated that staff would have a yearly appraisal and supervision four times a year. When we reviewed all the staff files, we found that one member of staff who started in July 2017 had one supervision record on file for January 2018. Another member of staff who also started in July 2017 had one supervision when they first started in July 2017 and another in January 2018. One member of staff had no supervisions on record at all and had started six years previously. This meant the provider had not followed their policy about how staff would be supported as they had not provided records to identify these had taken place.

We reported in the Safe domain of this report that the provider did not ensure that concerns raised by staff were dealt with seriously. Safeguarding concerns were not dealt with in an open and objective way. There was little evidence of what support staff had received to ensure they were adequately supervised in their role to ensure they were competent in their skills. Not all staff were confident in the management of the service. Staff comments included, "Communication with the office is diabolical", "The whole company is starting to come across scruffy and unprofessional" and "It could be better (when asked if the service was well-led). It's not easy to get hold of them [provider and deputy]. I have to call their personal mobiles as no-one answers the office phone". Another comment was "It's real hit and miss. Fundamentally the management don't get on any more and that has an impact".

The findings from this and previous inspections demonstrate that the provider does not have a full understanding of their responsibilities to ensure that all relevant legal requirements were understood and met, including CQC registration requirements. The provider had not acted upon enforcement action by the CQC to make and sustain the requirement improvements to ensure people received safe and effective care from a registered service.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Services have a requirement to send statutory notifications to the CQC about incidents, including safeguarding concerns. We found that not all notifications had been submitted as required. For example, the safeguarding concern we reported on in the Safe domain.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) regulations 2009

The registered provider was not required to have a registered manager as a condition of their registration for this service. 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 registered provider was supported by a senior carer in the management of the service. Both the provider and the senior carer also delivered care.

The staff team said there was supportive relationships between each other. This meant that people were kept safe as staff ensured they communicated with technology and on records to ensure people's needs were met. This meant people were protected from immediate harm.

The provider carried out surveys to seek feedback from people. One person told us they received surveys and were asked for feedback during visits. This was because the provider often support people directly and therefore was able to seek feedback on an ongoing situation. If the provider worked alongside a member of the staff team they were able to observe care delivery.

Despite the concerns identified during our inspection, feedback from people and their relatives reflected they thought very highly of the provider and the staff team that supported them on a day to day basis. No-one we spoke with expressed any concerns other than wanting assurance that their support would continue.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not made required statutory notifications to the relevant bodies.

The enforcement action we took:
Cancellation of registration

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive care and treatment in a safe way. Not all action reasonably practicable was taken to minimise risks. Medicines were not managed safely.

The enforcement action we took:
Cancellation of registration

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not adequate protected from potential abuse as systems were not operated effectively to investigate all allegations.

The enforcement action we took:
Cancellation of registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to monitor and improve the service were not effective.

	Records were not always accurate and up to date.

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured that all staff employed underwent necessary checks in line with legislation before working with people in the service.

The enforcement action we took:

Cancellation of registration

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not suitably qualified or assessed as competent to enable them to carry out their roles safely and effectively.

The enforcement action we took:

Cancellation of registration