Carers Elite Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**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 service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to approximately 80 older adults, younger adults and disabled adults predominately in West Norfolk.

Not everyone using Carers Elite Limited receives regulated activity; The Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

There was a registered manager in place. 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.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches relate to person centred care (Regulation 9), safe care and treatment of people using the service (Regulation 12), complaints (Regulation 16), good governance of the service (Regulation 17), staffing (Regulation 18) and fit and proper person employed (Regulation 19). We are taking action against the provider for failing to meet regulations.

Risks to people's health were not always identified. Where they were identified, the service had not always taken appropriate actions to minimise the risks to people's welfare. In some cases, potential risks to people had been inaccurately assessed. People were placed at risk.

The numbers of staff available and their deployment was not effective in ensuring people's needs were met in a timely way. People had received late and missed calls. These incidents were not recorded accurately and actions to avoid a repeat of these were not always taken.

Staff training and checks of their competency, to ensure that they could meet the needs of people, had not been fully completed. Staff did not receive supervision to support them in their role. Staff had not received appropriate levels of training in dementia awareness and end of life care. Recruitment of staff was not robust.

Staff were kind and caring but did not always respect professional boundaries. Staff sought peoples consent before providing them with support. Staff promoted and encouraged people to be as independent as possible.

People's care plans did not contain accurate, up to date or clear information for staff to help ensure that they provided a safe and good standard of care and support to people. People's preferences had not always been identified so that staff could provide care in the way people wanted.
Complaints to the service had been not been managed in line with the provider's stated procedure. They were not used to develop and learn and drive the service forward.

The provider's quality assurance was inadequate and auditing systems were not robust and had not identified the concerns we found during this inspection. Checks were not carried out to ensure that safe, good quality care was provided.

The registered manager had not completed an appropriate qualification as was required at the point of their registration with the CQC. The registered manager did not have sufficient knowledge and understanding of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

The overall rating for this service is 'Inadequate' and the service is in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The deployment of safe was inadequate. People had missed and late calls.

The provider had a recruitment process in place but this was not always followed therefore the provider had not ensured staff were suitable for the role.

Medicines were not consistently safely managed to meet people's needs.
Risks to people were not safely managed. Risk assessments were not in place to provide care workers with the information required when providing care.

Most people told us they felt safe when they received care in their own home.

Is the service effective?

Requires Improvement

The service was no consistently effective.

Staff training did not ensure staff had the knowledge and skills they needed to support people effectively.

Staff did not receive supervision or checks of their competency to support people.

People were supported to have enough to eat and drink, but care plans did not reflect the support required with eating and drinking.

Staff sought consent in line with the MCA but there was no system in place for staff to undertake an assessment should a person's mental capacity change.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some people's dignity was compromised and they were not always treated with respect.

Staff did not always ensure professional boundaries were adhered too.

Staff were kind and caring towards people.

People's independence was encouraged and promoted by staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

Care plans were not accurate and had not been reviewed.

Care plans did not contain clear instructions for staff to follow which meant that people might not have received appropriate care. People's preferences had not been identified.

Complaints were not managed appropriately or formally.

Staff had not received training in end of life care.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had failed to implement governance systems to monitor the quality of care provided or to mitigate risks to people's safety.

There was a lack of oversight that placed people at risk.

The registered manager had not completed the relevant required qualifications. The registered managers understanding of the Health and Social Care Act (2008) regulations and their responsibilities regarding this was insufficient.

Carers Elite 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 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 6, 7, 8, 20 February 2018 and was announced. We gave the service 24 hours' notice of the inspection visit because the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection site visit activity started on 6 February 2018 and ended on 20 February 2018. It included visits by an inspector to speak to people in their own homes on the 7 & 8 February 2018. We visited the office location on 6 & 20 February 2018 to see the registered manager and office staff; and to review care records and policies and procedures. The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise is care and support provided to older people and people living with dementia. The
expert by experience contacted people and relatives for feedback via the telephone.

Before the inspection, we reviewed information that we held about the service. Two whistle blowers who had concerns regarding the quality of the service in relation to enough staff being available had contacted us. During the inspection we followed up on these concerns received. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the statutory notifications the provider had sent us and additional information we had requested from the local authority quality assurance team.

We gathered feedback from eight people who were using the service and five relatives. We also spoke with five staff whose primary role was to deliver care to people in their own homes. When we visited the office we

spoke with two care co-ordinators who scheduled care visits and the registered manager.

We looked at documentation in relation to 10 people who received care from the service. We also looked at three staff recruitment/training files, the provider's training matrix and other information in relation to how the quality and safety of care was monitored by the registered manager and provider.

Inadequate

Our findings

Our inspection had been planned and brought forward because we received a number of concerns about the service including missed calls. We spoke with people who used the service over the telephone and by visiting them in their home. We also spoke with peoples relatives. We received mixed views from people about the quality and consistency of care provided and how safe this made them feel. Some people we spoke with raised concerns that calls were missed or that carers arrived late. We also found that some people had experienced a high turner over in the different carers that supported them recently. This left them feeling vulnerable. One person told us that they felt safe because, "They're a nice bunch and they know what they are doing". However, another person told us they did not feel safe because the carers were not regular and they did not know them.

Risks to people using the service were not adequately identified during assessments of people's care needs, and in the records staff used in order to support people. We found that all the care plans we looked at contained broad and generic information for staff to use in how to reduce the risks to people. Records did not contain enough detail for staff to follow, and had not been reviewed on a regular basis. The service started providing care to people in their own homes in June 2016 however, no reassessments or reviews of people care needs and risks to them had been carried out. People were placed at risk.

One person we visited had a recent change in need, which was not reflected in their care plan. Their key member of staff knew the person very well but had been off sick over the Christmas period. This had resulted in the person being supported by staff who did not know them so well. Staff would not be able to provide safe care to the person based on the information we saw in the care plan. For example, the care plan stated the person used a stand aid hoist to mobilise. The person told us this was no longer the case and they now required the use of a hoist with a sling to transfer. There was no current manual handling plan in place for staff to follow. A staff member told us that two staff usually supported this person with the use of the hoist, but on some occasions, the second member of staff had been delayed. They told us that they sometimes lifted the person by themselves rather than use the hoist if only one staff member was available. This put both the person and staff at risk from unsafe care and an increased risk of a fall or injury. The person had also developed pressure ulcers, which were being treated by the district nurses. There was no clear time line for when the person developed the pressure ulcer and nothing in their care plan about maintaining their skin integrity or what equipment was in situ. We discussed these issues with registered manager who told us that they would take action to address these issues immediately.

We saw that for one person who was receiving care for a deteriorating and life limiting condition, that there

was a lack of detail in the care plan as to how staff should support them. For example, they used a number of mobility aids, but the care plan just stated that staff should 'Use correctly' without detailing what that meant. It also stated that the person 'required assistance' when rising from a chair, but gave no further detail. This meant that staff who were unfamiliar to the person would not be aware of what they needed to do to support them safely.

We found that actions to mitigate risk to people where there had been an increased turnover in regular staff had not been taken. There had not been oversight by the registered manager and the care co-ordinators to ensure that detailed verbal or written handovers had taken place where staff and people using the service were not familiar. One person using the service told us that they had stopped receiving assistance to take a bath because, "You have to trust them to let them bath you, but because there are so many, I don't feel that I can trust them". They went on to say that they felt very upset and frustrated by this. Another person who had a fall recently did not have a completed falls risk assessment to understand how similar events could be prevented. One staff member said they supported the person to do regular exercises to keep them mobile but said this was not carried out when they were not on duty. They said when they returned the person had stiffened up again. This meant that actions to reduce the risk of further falls were not always undertaken when there was a change in regular staff members.

We spoke to the registered manager about how staff were assessed to be competent and safe when working in peoples own homes, often on their own. They told us that observations and assessments of staff competency did not take place when working in people's homes. There was no oversight mechanism in place to ensure that staff supported people in a way that was safe and ensured risks were minimised.

There was on going risk to people and staff as risks had not been adequately mitigated and people were not safe. We found negative impact upon people. Therefore this was a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Before our inspection we received concerns that Carers Elite Limited did not have enough staff, and that calls to people had been late or had been missed. The majority of people we spoke to during our inspection told us that they regularly received late calls, and that this had become a problem in December 2017 and had not yet improved. Two people and one person's relative told us that there had on occasions, been missed calls where staff had failed to arrive. They had also been contacted by the service to tell them that they were not able to send a staff member. One staff member told us that occasionally only one staff member was available to attend a call where two staff were required and expected. We were told that this had been an issue since before the last Christmas period.

One relative told us that their family member had received three consecutive missed calls. This included an evening visit in which care staff were meant to assist the person to bed and support them with a drink. Without this evening call, the person did not go to bed but slept on the sofa. This placed them at serious risk. This increased the risks of falls and dehydration and did not promote their usual routines.

The registered manager told us categorically that there had not been any missed calls to people. They also said that calls that were unable to be made due to staff shortages, had been notified to the person or their relative and were entered onto the care record as a cancelled rather than missed call. Usually a cancelled call is when a service user contacts the provider to say the call is no longer required. This meant that the registered manager was not accurately recording when a person had not received a call that they expected to be made. The registered manager agreed to address this urgently, and record clearly any missed calls so that the reasons for this could be analysed and resolved.

In discussion with the registered manager, it was clear there had been a number of changes within the organisation in recent weeks with a number of staff leaving or about to leave. This included the home care manager and the office manager. This had resulted in staff being taken away from providing care to prepare rotas and complete administration. Staff rotas were being planned at short notice and existing staff were covering extra calls but not always familiar with the person they were supporting.

The registered manager explained that most staff were on part time hours so were able to do extra shifts. However, they were not able to provide us a break down of essential and non- essential calls, which could be rescheduled if there were staff shortages without having a significant impact on people being supported. For example, domestic calls, or calls where people had the alternative of family supporting them. Staff recruitment was on going and there had been some success in recent weeks with appointing additional staff.

We concluded there were insufficient numbers of senior staff who had a clear oversight of the service. There was insufficient arrangements to ensure people received planned and cohesive care. Recent high sickness levels and staff turnover meaning there were not enough staff available, making the service chaotic, which had compromised the safety of the service provided to some people.

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

Recruitment processes were not robust. We reviewed records of staff recruitment at the service. Prior to recruitment original documentation was requested to confirm staffs identification, proof of age, address and eligibility to work in the country. The application form looked at staff's previous employment and references requested. However, some references were not received until after staff had commenced employment. In one case, no references were received until two months after the staff member had started employment. We brought this to the registered manager's attention who was not aware that this had occurred. There were checks in place that should have identified this but had not been completed on some occasions. The registered manager did not complete audits of recruitment files to ensure that safe recruitment of staff had taken place and any deficits identified.

Matters arising from the references or application form were not always explored and recorded. For example, one reference said, 'would not re-employ.' This had not been discussed as part of the interview process or noted on interview records. We concluded that the registered manager did not have appropriate systems in place to ensure that staff were suitable to work with vulnerable people.

This was a breach of Regulation 19 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Disclosure and barring checks were in place and the registered manager was clear on the processes they would put in place should an applicant disclose a conviction, which might affect their employment. Any offence would be considered in line with the risk and an assessment of this put in place.

The registered manager told us that staff did not undertake medicines administration other than for prescribed creams, and that staff only prompted people to take their medicines. Staff received full training in prompting people to take medicines as part of their initial induction. This included question and answer sessions to assess their competence. Staff we spoke to confirmed this. We viewed a number of care records and saw medicines charts showing medicines as being taken when promoted. Where prescribed creams were needed to be applied by staff, administration records had not always been signed regularly to show

that this had happened. Body maps were not used to show staff where and how the creams should be applied. Some creams were prescribed to be used 'as required' but we could not see clear guidance for staff to follow so they would know when to administer them.

Care plans contained contradictory information about what support people needed with their medicines. For example in one care plan, it said the person needed prompting with medication. Later on in the record, it stated the person was independent with medication. This meant there was a risk that staff would not know to prompt the person to take their medication.

We visited a number of people; one person had a small tablet on their table, which they had not taken. They had a degenerative eye condition. Their care plan did not include a risk assessment or an assessment of their ability to take their medicines safely. There was no mention in their care-plan that they had poor vision, which might affect their ability to do things safely. The registered manager had not assessed if any of the care calls were time critical, for example if people needed medicines at a certain time or if they were to be taken before meals. This information is important to staff so they can prioritise calls, or alert the person or their relative if they are delayed in any way so that alternative arrangements can be made.

Staff we spoke with understood their responsibilities to raise concerns and record safety incidents and near misses. The registered manager understood the need to report these concerns to externally bodies such as the local authority of the Care Quality Commission. However, the registered manager did not have in place any formal systems to demonstrate that when things had gone wrong, that the reasons for this had been fully explored. The registered manager told us that they always looked to learn and make improvements to reduce the reoccurrence of incidents, but could not give us an example or show us records of this. The registered manager told us that they would implement a system to do this without delay.

Staff received training in infection control and said they had enough personal protective equipment, which they used when carrying out care tasks. All of the people and relatives we spoke with told us that they saw staff use this equipment when providing support to them. However, the registered manager did not undertake spot checks of staffs practice in this area, which is particularly important as staff often work unsupervised in peoples own homes. These checks would ensure staff followed good infection control procedures.

Staff had a knowledge of safeguarding people from abuse and how and who to report concerns to. Staff said they were given a staff handbook when starting work. However, another member of staff said they had not been given a handbook. Staff said the handbook included key policies they needed to be aware of, including reporting safeguarding concerns. Staff were confident that the provider would take appropriate action if they raised a concern to them. We saw that staff had undertaken training in safeguarding at the commencement of their employment. However, staff did not receive supervision, or have the opportunity to attend meetings where safeguarding matters could be discussed. This meant that staff were not encouraged or empowered to understand what keeping safe means and how they could promote this.

Requires Improvement

Our findings

Staff told us they were confident in their role and most had previous experience of working in care. Staff said they undertook three days of induction training in the office, which was a mixture of classroom based and online training. Staff told us that after induction training was completed they shadowed staff that are more experienced. However, there was no record of this taking place. The registered manager told us that this, along with checking of staff competency, was undertaken in residential care homes that Carers Elite provided staff to. However, there were no records of this either. We asked if staff competency was checked when working in the environment of peoples own homes, and were told by the registered manager that this did not happen. The provider's policy on staffing stated that staff should undergo an annual observation of working in people's homes.

Most staff felt the training was adequate. One staff member said, "Its better training than I had before". However, another member of staff said they did not think the training was adequate for staff new to care. Another staff member told us they completed updates to their training after a certain time. Staff told us how they supported younger people with complex and permanent physical conditions for which they had received no specific training. In addition, staff told us how they had supported people approaching the end of their lives. However, they had not received any training in end of life care.

One relative we spoke with told us that they did not feel that staff had enough training and knowledge in proving care to people living with dementia. We asked staff about dementia care. Staff said they covered this but only briefly, whereas other staff said they had not done this. The registered manager told us that staff only undertook basic awareness training in dementia care, but had arranged for all staff to completed advanced training in this area in the near future.

The registered manager was not able to tell us how often staff received supervision and there had been no recent observations of practice of staff in the workplace. Supervision and appraisal of staff performance is an essential part of ensuring staff development and competence to support people appropriately. There were no records to demonstrate that staff had received supervision and an annual appraisal. The provider's policy states that staff should receive six face-to-face supervisions a year and an annual appraisal. We concluded that the assessment of staff performance did not take place in line the providers stated policy and procedure. This meant the registered manager could not be sure that staff were competent to carry out their role.

This was a further breach of Regulation 18 of the Health and Social care Act 2008 (Regulated Activities)

Regulations 2014.

The registered manager told us they were aware of best practice guidance such as that outlined by NICE (The National Institute for Health and Care Excellence). The policies and procedures we reviewed referenced this guidance. However, this guidance was not followed when assessments of care were undertaken.

People's care needs had not been assessed in enough detail and did not identify people's preferences in all areas of their life. We saw records for some people did not contain information such as their preferred name, method of communication, likes and dislikes and what was important to them. The care plans we saw did not include people's preferred priorities of care or what they might wish to happen if terminally ill.

Where people may have had a protected characteristic as identified in the Equality Act, assessment of people's needs had not explored this. This meant people were at risk of being discriminated against. Important issues to people such as the times of their call visits and the gender of the carer they wanted visiting them had not been adequately assessed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so or 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 to see if the principles of MCA were followed.

The registered manager told us that all of the people receiving a service from Carers Elite Limited had the capacity to consent to receive the care provided. However, there was no system in place for staff to undertake an assessment should a person's mental capacity change. The registered manager and staff did not demonstrate an understanding in this area when we spoke to them about this. However, staff were clear that they should always seek peoples consent before providing them with support, and could give us examples of how they would do this. All of the people we spoke with during the inspection told us that staff always checked that it was okay to support them before doing so.

Staff told us they supported people with eating and drinking if this was a defined need. The people we visited did not have plans in place around their nutritional needs This is important to ensure that staff provide people with care that has been assessed as being needed. However, we saw staff preparing meals and leaving drinks and snacks within easy reach. Most people we spoke with told us that they were happy with the support they received around eating and drinking. They told us that their preferences were met, and that staff ensure that they had access to enough drinks when they left. However, some people felt that staff needed basic training in some cooking tasks to improve the quality of what was made.

Most of the people we spoke with arranged their own healthcare. However, they told us they felt confident that staff would support them with this if required. One relative told us, "They [staff] phone the GP if I'm out, they have rang the district nurse before too". Records showed and staff told us that they reported concerns to various professionals such as the person's GP or district nurse if needed. We saw that staff had contacted emergency services when required. We concluded that people were adequately supported to access healthcare when needed.

Requires Improvement

Our findings

Staff spoken with had caring values and told us how they supported people and felt responsible for ensuring their needs were met. Staff who provided people with support on a regular basis built up relationships with them. This included learning about people's life history and backgrounds. However, this was not documented or identified in peoples care plans. This meant that when there was a change of staff, this information could not be gathered. People received support from staff who were unfamiliar with this essential information.

People gave us mixed feedback about how often they were able to express their preferences and review the care they received. One person told us that they were able to tell staff what they wanted, and that staff always provided this for them. They went on to say they had not had a review since starting to receive care over a year ago, and did not know that the service should complete them. Another person told us, "I used to make the decision about what cares do, but now it's just mainly what's written down. When they [staff] first came I decided what I wanted doing, but no one has asked me again". They told us that they had been receiving support from Carers Elite for around a year.

A relative we spoke with told us that they felt involved in arranging the persons care when the initial assessment was completed. However, they told us that the control of those decisions had disappeared. They told us that carers changed very regularly, and that staff and the agency, "Now choose the times to arrive". We concluded that improvements were needed to insure that people were involved in making decisions about their care and that this is continually reviewed.

People and their relatives that we spoke to told us that staff were kind are caring in their approach to them when providing care and support. One person said, "They [staff] are very caring, they cheer me up". Another person told us, "We sit and talk a lot, they tell me about their children, we share our stories". Another person told us that a staff member brought them some homemade chicken stew, they said, "It had dumplings, the lot, it was very caring, and delicious." A relative said to us, "They're wonderful, really caring."

Some people told us that on occasions some staff crossed professional boundaries, which they were not happy about. One relative gave us an example of staff putting on makeup and getting changed to go out after work at their house. They felt that they should not have done this in the person's home, and had not asked if it was ok to do so. We were also told by a relative that a staff member brought their children with them when carrying out a call to a person. We raised these concerns to the registered manager who agreed that this was unacceptable and would take action to address this.

The majority of people we spoke with told us that staff treated them with dignity and respect, and help to maintain and promote peoples independence. People gave us examples of how staff did this, such as ensuring curtains were drawn when providing personal care. One person told us, "She [staff] offers me encouragement to get about using my sticks". A relative told us that staff provided encouragement to their family member to use a walking frame to mobilise around their home.

Requires Improvement

Our findings

During our inspection, we reviewed the care records for six people. We saw that all of these had incomplete sections including those which covered people's preferences and personalised care. Although some staff had detailed knowledge about people's preferences, which had been built over time, people told us that they were increasingly sent care staff who did not know them. There had been increasing inconsistency in the core group of carers deployed to support people caused by the recent staffing issues.

Some people were happy with their care because they had regular carers they got on with and who knew their needs well. Others said they did not have regular carers and staff were arriving late. This resulted in people cancelling the calls because the service could not be relied on and people made other arrangements, such as asking a relative to help them. We asked the registered manager for information about how late and missed calls were responded too. They told us they did not do a root cause analysis as to why care calls were cancelled by people using the service. This might have alerted them to some of the issues we identified.

Care plans we reviewed showed the date of the initial needs assessment was often conducted months before the support started, and was very basic and generalised in nature. After support was started, the care plans were then not reassessed to ensure that any changes or new and detailed information was incorporated. This made it difficult to see how people's needs were being met or how staff were expected to know what people's needs were. Staff told us they had basic information before delivering the care. However, this was insufficient for people who had complex care needs or multiple visits.

People we spoke with did not have care plans that reflected their needs. For example, we met a person who had significant health issues. They had poor skin care and there was no manual handling plan in place. They were at risk of developing sore skin due to a poor routine around their personal hygiene.

The information in care plans varied but did not reflect people's preferences such as preferred time of call. The care plans did not give specific information such as what people could do for themselves and how staff could enable people's preferences. Some care plans had no information about the purpose of the support, any individual goals people wanted to work towards or what the persons circumstances were which led them to needing support. This would help staff help the person achieve what they wanted.

Some information was inaccurate. For example, one care plan said the person did not have a hearing impairment. In another section, it said the person wore a hearing aid. This is an important factor in the

persons care. Another person we met had impaired hearing and failing sight. Although the person was able to tell us about their needs their sensory loss had an impact on communication and initially they missed some of the communication. Staff might be unaware of how to effectively communicate with them, as there was nothing about this recorded in their care plan. They said to us care staff did not read the care plan and they had to tell them when they arrived what their needs were.

Some records were not updated or signed so we could not see if the information was relevant or up to date. We asked the registered manager how they were reviewing the care provided in the absence of regular reviews. They told us staff were currently updating care plans but could not tell us how many were up to date, how many were still to be reviewed or what systems there were in place for review. They told us daily notes were transferred to the office and checked over for accuracy. However, no formal data for this could be provided and the retrieval of notes had not been completed consistently.

We concluded that the planning and recording of peoples care, and the reviews of this did not ensure that people received personalised care. The management and deployment of staff and recent staffing shortages meant had an impact on people receiving personalised care. People received care from staff they were not familiar with.

This was a further breach of Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that the service had not received any formal complaints. They said some concerns had been received but these were dealt with informally. We asked the registered manager to provide us with records relating to this, but told us that none existed. We spoke to people who told us that generally they did not need to complain but would if they needed to. However, some people told us that they had complained in the past, and has been dealt with to their satisfaction. Even though complaints had been received no records existed for inspection purposes to demonstrate how they had been managed.

Providers of social care are required to have in place a system to ensure complaints are responded to. The provider's statement of purpose states that all complaints will be responded to within 24 hours, with an outcome within 28 days. The service user guide issued to people using Career Elite states complaints will be acknowledge within three working days. It also states that a full investigation will commence and agreed actions will be logged including the time frame to resolve this on a complaints log sheet. This meant that service users had been given a different set of timescales to respond to complaints than what the provider had told the Care Quality Commission. In addition to this, the registered manager had not processed complaints within the providers stated process. Complaints and concerns were not used to check if any lessons could be learnt and improve the quality of service to people. We spoke to the registered manager about this who told us that they would now log all complaints and concerns within the providers stated process.

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

Carers Elite staff provided care to some people who had a terminal illness or life limiting condition. Staff provided personal care to people alongside nursing and medical professionals. However, staff had not received any training in supporting people who were at the end of their lives. Staff could tell us what they would do in the event of a person's death, and how they would support them and their families prior to this. However, people's needs and preferences for their end of life care had not been identified in people's care plans. This meant that any staff not familiar with the person or their family, would not be able to provide the

support they needed, at such a sensitive time.

Inadequate

Our findings

At this inspection, we found insufficient governance systems in place to monitor quality and drive improvement. We found multiple breaches of the regulations. There was a registered manager in post who was also the sole director of the provider, Carers Elite Limited. Since the service registered with the Care Quality Commission (CQC) in June 2016 to provide the regulated activity of personal care, no audit system had been established so that checks on the quality of the service could be undertaken.

At the start of our inspection visit, the registered manager shared with us that the service had experienced several challenges in the recent past. These related to the running of the service and the deployment of staff by managers within the business. The service had recently changed a number of key service delivery personnel. The issues experienced included the rostering and deployment of care staff, which had not been undertaken efficiently. This had resulted in staff being delayed in receiving their rotas. They told us that this had an impact on the service delivery, particularly over the recent Christmas period.

However, the data we reviewed regarding missed, cancelled and late calls did not reflect this. The way in which the service recorded information around missed and late calls was inaccurate and misleading. For example, where a person's call could not be made because of staffing shortages, the person had been contacted on the first occasion to inform them of this. The person told us the next two calls were also missed, but they were not informed that this would occur. These missed calls were recorded by the registered manager as cancelled calls rather than missed calls. Therefore data was consistently incorrect.

We found that the registered manager had not had adequate oversight of the service. They were not aware of people's needs, how their care was being delivered and if this was meeting their needs. Shortfalls in the provision of service identified at this inspection, had not been identified in a timely way by the registered manager. Some of these occurred in excess of a year ago. Systems to ensure people received the care they needed were ineffective. Audits of peoples care plans had not taken place and had not identified shortfalls in relation to the care people received.

Customer satisfaction checks or audits had not been fully completed. We saw in people's care plans that they had been asked to give feedback about the service in a questionnaires. Those we saw asked a series of questions which people ticked their preferred answer. These were of little value as results had not been collated and there was no evidence people were contacted for their feedback. Some people we met had sensory and cognitive impairment and may have not been able to use the form to give feedback. People and their relatives told us that the quality of service had significantly declined in the past six months. They told

us that when they contacted the service they were concerned information was not always passed on or actions taken were ineffective. We found ineffective systems in place for managing and dealing with complaints made.

The systems for assessing, monitoring and mitigating risk were ineffective. Risk assessments were partially completed and contained basic and generic information. They were not reviewed so that any changes could be made if required in line with peoples deteriorating health. For example, where a person had a fall, there was no further information about what had happened or what was in place to reduce the likelihood of falls occurring again.

Systems to ensure staff were adequately trained and supported were ineffective. Staff had not received all of the training and checks of their practice required to meet people's needs. Some staff did not think they had all the support and training required to carry out their role effectively. The systems had not ensured all staff had the skills and knowledge to be able to care for people living with dementia.

Systems to ensure people received consistent caring and compassionate support were ineffective. Some people were not consistently treated with dignity and respect and their privacy was not always considered. People were not always supported in line with their preferences because they had not been asked what these were. Systems for ensuring people had a good quality of life that responded to their individual needs and received person centred support had not been implemented.

The systems in place had not ensured all of people's individual health needs were assessed and planned for which impacted negatively on people. For example, where a person had a fall and was taken to hospital, no further information was provided. Later in the care plan, it stated that the person would benefit from an occupational therapy assessment but this was not followed up. Systems for ensuring that people were supported to have their human rights upheld had not been effective in ensuring people's rights were fully protected.

There was an informal approach to managing the staff team at Carers Elite. The registered manager told us that he worked hard to ensure that staff found him approachable and open. Staff we spoke to confirmed this. However, staff meetings did not take place, and newsletters were not sent to staff. Staff did not have an allocated line manager, and the supervision and appraisal of staff performance had not taken place. There had been a breakdown in the relationship of key staff who operated the service resulting in some of them leaving at short notice. This had impacted upon the deployment of staff.

At the point in which the manager registered with the CQC, they agreed to complete a national recognised diploma in the management of health and social care services. The registered manager had not however completed this training and had not made any progress towards achieving it. In our discussions with the registered manager, we found that they had a very limited understanding of the regulations and responsibilities expected of them under the Health and Social Care Act (2008).

The registered manager assured us they would manage the service and make significant improvements in the next three months. However, despite these assurances there was no clear action plan as to how they were going to do this and what staff they needed to provide clear lines of accountability and responsibility.

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

Staff spoken with said they felt well supported and that the registered manager addressed any concerns

they might have. Staff told us they were happy and had enough time to deliver the care needed. They told us they all supported each other, and there was a good team spirit and morale was high. We asked how the provider communicated any important changes within the service. Staff said usually happened by text message. Staff said support was informal and they could visit the office to discuss any issues or changes in people's support needs.

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Peoples care had not always been planned and delivered to meet people's individual needs

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems for managing and minimising risks and the monitoring of this did not properly contribute to people receiving safe care and treatment. Actions were not taken to investigate all accidents or incidents.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints had not been responded to and investigated properly.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to assess monitor and

improve the quality and safety of the service provided and to assess monitor and mitigate risks relating to the health, safety and welfare of people living in the service were not effective. An accurate and complete contemporaneous record in response of each person using the service was not in place. Feedback from people had not always been acted upon.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment processes were not robustly applied to contribute to protecting people from the employment of staff who were not suitable to work in care.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The providers assessed level of staffing did not always ensure people's needs were met in a timely way that promoted their safety. Staff did not receive regular supervisions, and competency of their practice was not assessed.