Horizonz Care Ltd

# Horizonz Care

## Inspection report

56 Wellington Street
Batley
West Yorkshire
WF17 5HU

Tel: 01924430744

Date of inspection visit:
06 January 2016

Date of publication:
20 January 2017

## Ratings

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

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

# Summary of findings

## Overall summary

The inspection of Horizonz Care took place on 6 January 2016 and was unannounced. Horizonz Care was registered with the Care Quality Commission in April 2014. This was the first inspection of the service since their registration.

Horizonz Care is registered to provide personal care. Care and support is provided to people who live in their own homes within the Kirklees area. One the day of our inspection 27 people were receiving support with personal care.

The registered provider is also the registered manager for the 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.

During our inspection we found people were not adequately protected from the risk of harm or abuse. We noted examples of incidents which had not been always been referred to the local authority safeguarding team and the registered person had failed to report these matters to the Care Quality Commission. This demonstrated a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Risks to people's welfare had not been robustly assessed and relevant risk assessments had not always been implemented. Staff had not been assessed to ensure they were safe and competent to administered peoples medicines. Records relating to peoples medicines were inadequate. This demonstrates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment of staff was not robust. We found staff were employed without references and we were not always able to evidence a Disclosure and Barring Service (DBS) had been completed for all staff. This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with did not feel staff had the skills to meet their needs. Evidence to support staff had completed relevant training, was lacking. Staff told us they shadowed a more experienced staff member when they commenced employment but this process was not formally recorded or evaluated. Feedback from the registered person, care co-ordinator and staff was conflicting regarding supervision; however, we did not see any recorded evidence of staff supervisions to monitor staff performance and development. This evidence demonstrates a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that where people lacked capacity about their care and support, a record of this assessment had

not been completed. This demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although people told us most staff were caring and kind, we found staff did not consistently respect people's privacy or dignity. This demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Each person had a care and support plan in place which recorded their individual support needs at each allocated call.

People were aware of how to complaint but complaints were not formally logged, investigated or acted upon. This demonstrated a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff personnel files and both paper and digital records for people who used the service were not stored securely. The organisation did not have an effective quality assurance and governance system in place to drive continuous improvement. There was no system to ensure the views of people who used the service were routinely gathered and acted upon. This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

People were not protected against the risk of harm or abuse.

Recruitment processes were not robust.

Medicines were not managed safely.

### Is the service effective?

**Inadequate**

The service was not effective.

People told us they did not feel staff had the skills to perform their role.

Staff did not receive adequate induction, training or supervision.

Where people lacked capacity, mental capacity assessments were not completed.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

Staff did not consistently respect people's privacy, dignity and personal preferences.

Staff told us how they supported people to make choices about their daily lives.

Peoples support records and staff personnel files were not stored securely.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Care plans recorded the care and support people required.

Care plans were reviewed but we could not consistently evidence

that people were involved in this process.

People were aware of how to complain but complaints were not effectively acted upon.

## Is the service well-led?

**Inadequate**

The service was not well led.

The registered person was involved in the management of the service on a daily basis.

There was an absence of systems and processes in place to ensure robust auditing at the service.

There was no system to effectively gain the views of staff and people who used the service to ensure the quality of service to people was of a satisfactory level.

# Horizonz Care

**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 January 2016 and was unannounced. The inspection team consisted of four adult social care inspectors and one adult social care inspection manager.

Before the inspection we reviewed all the information we held about the service including notifications, and we spoke with the local authority safeguarding team. We had also received information of concern from an anonymous source regarding the staff recruitment, staff training, medicines management and concerns to people's safety and welfare. At the time of the inspection a Provider Information Return (PIR) was not available for this service. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. On this occasion we had not asked the provider complete this document.

During our visit we spent time looking at nine people's care and support records. We also looked at 17 records relating to staff recruitment and training, and various documents relating to the service's quality assurance. We also spoke with the registered person, care co-ordinator and a senior support worker. On 11 January 2016 one inspector telephoned and spoke with two people who used the service and six relatives of people who used the service. On 12 January 2016 two inspectors visited four people in their own homes and spoke with them and/or their relatives. One inspector also spoke with six staff on 13 January 2016, including two who had stopped working for the service within the last four months.

Inadequate

# Is the service safe?

## Our findings

We asked people who used the service if they felt safe and we received mixed feedback. Two relatives we spoke with told us their family member was safe, however, three relatives and one person who used the service expressed concern regarding staffs safe use of moving and handling equipment.

During our inspection of the service we found people were not protected against abuse or the risk of abuse.

We asked the care co-ordinator, senior support worker and four support staff about their knowledge of safeguarding. All staff except one were able to describe types of abuse and said they would report any concerns to senior staff or the registered person. However one staff member was unsure if they had received training or what constituted abuse. Following the inspection we were provided with staff training certificates for twenty staff; we saw only four staff had completed safeguarding training.

During the inspection we found examples of recorded incidents which had not been identified as safeguarding concerns and had not been investigated or reported to the relevant authorities. For example, the registered person told us a member of staff had inadvertently caused bruising to a person's hand. The registered person said they had referred this to the local authority safeguarding team but they had not submitted a statutory notification to the Care Quality Commission (CQC) regarding this incident. The registered person said they were not aware they should have done this. The registered person also told us a member of staff had notified them that there had been an incident where an amount of money had gone missing from a person's home. The registered person told us they had discussed the matter with the person's relative, this was later confirmed when we spoke with them, but the incident had not been reported to either the local authority safeguarding team or to CQC. This showed the registered person was not aware of their responsibilities in relation to safeguarding the people they cared for and the requirements placed upon them to make statutory notifications under the 2009 regulations.

We asked the registered person if they were aware of any people's calls being missed. They said they were aware one person's night call had been missed. When we spoke with this person's relative after the inspection they said their relative had had a 'couple of missed calls in the last six months'. They told us their relative had 'come to no harm' but on one occasion the person had spent the night in the chair because they had not been supported to bed. There was no evidence this incident had been investigated, or referred to the local authority safeguarding team and a statutory notification to the CQC had not been made. This demonstrated the registered person was not fulfilling their regulatory responsibilities in keeping people safe from the risk of harm.

When inspectors visited the home of one person who used the service they saw the following entries in their daily logs: 11 August 2015 'leg got stuck and foot got twisted', 5 October 2015 'feet got twisted when moving to bed'. There was no evidence these incidents had been reported to senior staff, referred to the local safe guarding authority or that the service had made the necessary statutory notification CQC.

This evidence demonstrates a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014 and a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We saw risk assessments in each of the care and support records we looked at. These were not reflective of all the risks identified with individuals' care. For example we looked at three people's notes where they required the use of specific moving and handling equipment. None of these risk assessments recorded the extent to which the person could participate in/cooperate with transfers, the specific equipment staff were to use, including the type of hoist and sling, sling size and which attachments were to be used. This meant care and support was not planned and delivered in a way that reduced risks to people's safety and welfare.

When we visited the homes of two people, we saw they had ceiling tracking hoists. The care records did not refer to the hoist being a ceiling tracking hoist and not a mobile hoist and there was no risk assessment or instructions in place for the action staff should take in the event of the ceiling tracking failing. This meant that in the event of the ceiling tracking hoist failing there were no risk assessments or written instructions to guide the staff as to the action they should take to move and handle the people safely.

We noted care records for another person detailed they 'suffer from seizures on a monthly basis'. There was no instruction within the care plan that recorded the action staff should take in the event of the person suffering a seizure in their presence. This placed this person at risk of harm.

Each of the support plans we looked at contained an environmental risk assessment which included access to people's homes, appliances within the home and parking. None of the risk assessments recorded the location of emergency cut off points in peoples home. For example, in the event a member of staff found a water leak at someone's home they would not know the location of the 'stop tap' to switch the water off. Having this information accessible enables staff to take prompt action in the event of a problem being identified.

These examples evidence a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of our inspection we reviewed 17 staff recruitment records and we found recruitment practices were not safe or effective.

The registered person and the care co-ordinator told us potential candidates were interviewed and the interviewer took notes and completed a scoring sheet, this was retained in staff files. When we reviewed the staff personnel files there was no record that an interview had been held with 12 of the 17 staff files we reviewed. We also asked the registered person and the care co-ordinator if a candidate would still be employed if they could not provide two suitable references. They both said yes, the registered person said, "Yes, if all else went well I would still employ (candidate)." When we reviewed the staff personnel files there was no evidence that references had been applied for or received for the care co-ordinator, senior support worker or 11 support workers. Therefore the provider was unable to evidence safe and robust recruitment practices had been followed.

The care co-ordinator told us a Disclosure and Barring Service (DBS) check was completed for all staff. However, there was no documented evidence a DBS check had been applied for or received for the care co-ordinator or eight support workers. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. Following the inspection the registered person provided us with evidence of the staff who had a DBS check in place. We saw from this evidence five staff who were employed by the service at the time of our inspection did not have a DBS in place. This

showed staff had not been properly checked to make sure they were suitable and safe to work with people.

This evidence demonstrates a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One relative we spoke with said there seemed to be a high turnover of staff and their family member was always seeing new staff. They said, "We have a period of being settled, then unsettled for a bit." A relative said they had been promised a rota, "But this never materialised." A person who used the service said, "Sometimes there are three or four different carers in a day." We reviewed the call logs for one person who needed two staff, four times a day. Over a twelve day period we saw there were ten different staff names listed who attended these calls.
When we asked people who used the service if staff arrived on time, feedback we received was negative. A person who used the service told us, "You're lucky if you get them on time." They went on to say they did not feel the care visits were well planned for the support workers and they did not think the service employed enough staff. Another person who used the service said carers were often late, they never knew which carers were coming to attend to them and no-one ever rang to tell them what was happening. One relative told us, "Morning and tea time calls are horrendous, sometimes and hour or two late. They never ring to say (they will be late)." Another relative said staff were often late to arrive but then left on time. They said, "Yesterday for a half hour call they were here for 12 minutes". This meant their relative was not receiving the allotted length of time allocated to them and for which they were being invoiced.

This evidenced the registered person had not ensured sufficient numbers of staff were deployed to ensure they could meet people's assessed care and support needs. This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we spoke with the management team about the training staff received in medicine administration, the information was conflicting. The registered person told us staff completed medicines training via an online course and they thought the care co-ordinator did an assessment of their competency. When we asked the care co-ordinator, they said staff completed an online course in medicines administration but said there was no practical element to this training. Staff also confirmed they had completed online training regarding medicines administration but they were not able to confirm that a member of the management team had ever observed them supporting people with their medicines to ensure they were competent to do so. Following the inspection we were provided with staff training certificates for 20 staff, we saw only 12 staff had completed medicines training.

The registered person and senior support worker told us staff prompted people with their medicines but did not administer to anyone. This was not confirmed when we spoke with staff, people who used the service or reviewed peoples care records. One relative told us their relative's medicines were kept in a locked cupboard which staff had access to, the staff then gave their relative their tablets twice a day. Another relative said "Staff take the pills from the Dossette box (an individualised boxes containing medications organised into compartments by day and time) and give them to (person) and put them in their hand". The relative also said staff applied cream to this person. A member of staff told us for one person they supported they took the medicines from the Dossette box and placed the content in the hand of the person. This evidenced staff were administering medicines to people and were not just providing a verbal prompt.

We saw the systems for recording people medicines were not safe. For example, we reviewed one person's medication log which recorded a start date of 1 December 2015 and covered a 28 day period. The document did not record the name of the service user or any detail regarding the medicines which were prescribed or administered. The relative told us the person was prescribed 'about 8 tablets a day'. We saw staff placed a

'√' to indicate medicines had been administered but this recording was inconsistent. For example the first week on the sheet, there was only a '√' for the evening medicines and not for the morning medicines. A further week on the same document, between Monday and Friday, there were only two ticks recorded from a potential 10. This meant there was no accurate record of what medicines had been administered, if they had been administered in line with the directions of the prescriber or whose responsibility it was to ensure the service user took their prescribed medicines.

We reviewed six medication logs for another person. Each log covered a 28 day period and did not record any detail regarding the medicines that were prescribed or administered. There were also numerous gaps where there was no entry to detail if the person had taken their medicines. For example, on the log dated 10 March 2015 of a possible 112 entries, there were nine gaps and on the log dated 29 June 2015 there were no entries recorded for the final 14 days. This meant there was no accurate record of what medicines had been administered, if they had been administered in line with the directions of the prescriber or whose responsibility it was to ensure the service user took their prescribed medicines.

These examples demonstrate a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service effective?

## Our findings

People expressed concern about staff skills and competency. One relative we spoke with did not feel staff were competent in the use of their family member's moving and handling equipment, they said "One staff teaches another, I'm not sure they get proper training of the hoist." Another relative also said staff did not receive adequate instruction when using hoisting equipment. They told us staff may shadow an experienced staff member on the morning call but then be expected to complete the task at the next call.

We asked the registered person how staff learnt the practical element of moving and handling people. They told us the local authority moving and handling team had taught a support worker and they taught new staff. We asked if the support worker was a moving and handling facilitator, we were told they were not. This meant the support worker was not appropriately qualified to teach other staff safe and correct moving and handling skills.

When we reviewed staff personal files there was no evidence of training. When we spoke with staff they told us they completed a variety of online training courses. However, two support workers we spoke with told us they had recently left the organisation due to a lack of training. Following the inspection we were provided with staff training certificates for 20 staff, we saw only ten staff had completed training in the theory of moving and handling and there was no evidence to support staff had received practical moving and handling training.

When we spoke with the management team about staff supervisions the information was conflicting. The registered person told us staff received four supervisions per year and they were recorded in staff files. The care co-ordinator told us they were in the process of setting up staff supervisions. When we looked at staff files we did not see any recorded evidence of any supervision in any of the files. One of the staff told us they had received supervision two weeks ago, another staff member said they had not received any supervision. This meant the provider was unable to demonstrate staff received regular, formal management supervision to monitor their performance and development needs and ensure they had the skills and competencies to meet people's needs.

We asked how new staff were supported when they commenced employment. The care co-ordinator told us staff shadowed a more experienced support worker for three days, unless more time was required. They said the process was not recorded, "We just communicate between ourselves and decide if they are ready". One of the staff who had recently left Horizonz Care told us they had been employed as senior support worker and they had been expected to teach other staff but they had not received any training themselves. When we spoke with other support workers they confirmed they had shadowed another support worker when they commenced employment, although there was no evidence in the staff personnel files to record staff had completed any shadowing or induction process. This meant there was no record which evidenced new staff were provided with adequate support when they commenced employment.

This evidence demonstrates a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

We asked two support staff if they had competed training in the MCA, one said they had and the other had not. The staff who said they had received training expressed understanding of capacity and supporting people with decision making. Following the inspection we were provided with staff training certificates for 20 staff, we saw only four staff had completed MCA training, this included the registered person.

The registered person told us they provided support to two people who lacked capacity. We asked if capacity assessments were recorded in people's support plans and they told us they were. They showed us an example but when we reviewed this document we saw it did not make any reference to mental capacity or decision making. The relative of one person told us their family member's medicines were kept in a locked cupboard which staff accessed. This indicated the person lacked capacity to manage their own medicines however, when we reviewed their support plan we did not see evidence of a capacity assessment.

This demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people who received a service from Horizonz Care also had support with preparation of meals, eating and drinking. We saw people's support plans recorded the assistance which was required, for example, preparing and serving meals and drinks. However, one person we spoke with was not happy with this aspect of the service as they said staff who attended to their call did not always have the necessary skills to prepare and cook their food of choice. This showed the provider was not ensuring staff were able to meet people's individual requirements for eating and drinking.

People's support records contained relevant contact information. This included the name and contact details for the person's GP. This meant that in the event of medical advice being required staff had the information they required to contact people's local doctor's surgery.

Requires Improvement

# Is the service caring?

## Our findings

When we asked people who used the service if they thought staff were kind and caring. Most people told us they were. One relative told us, "Staff are generally kind and caring although I think some are doing it for the money." People told us they did not get regular support staff and they were always having to tell staff what to do. One person said, "I have to tell them what to do every day." Another person said, "I'm like a parrot, repeating myself, telling them what to do."

One person we spoke with said if staff had been smoking, the odour made them feel nauseous. They said they had told one staff member about this and they had laughed at them. This showed this staff member had not respected the individual's personal preferences or treated them courteously.

One person we spoke with told us staff had no respect for maintaining their dignity. A relative said they had asked staff to close internal doors when delivering personal care to their family member but staff often forgot. However, we asked three staff how they maintained people's dignity and they were able to clearly describe the things they did. For example, closing doors and curtains and using towels to ensure people were not overly exposed while being washed and changed. This meant that not all staff were ensuring people's dignity and right to privacy when delivering personal care.
This demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The registered person and care co-ordinator spoke about the service and the people they provided support to in a kind, caring and professional manner. When we visited two people's home we saw information provided by the organisation which detailed the philosophy of care, the 'standards you have the right to expect' and information about privacy and dignity. There was also information on how to obtain this information in an alternative format if required.

We asked one of the staff if they could explain the concept of person centred care. They told us about the personal tasks they completed for people but did not demonstrate any understanding of planning and implementing people's care around their individual likes, needs and preferences. However, three other support workers we spoke with told us how they supported people and how they enabled people to make choices about their daily lives. For example, one staff member said they would open the person's wardrobe and encourage them to choose what they wanted to wear. Another staff member told us when they took one person out to a coffee shop they enabled the person to choose and did not make the choice for them.

One relative said their family member required two staff for every call, they explained the registered person ensured at least one of the staff attending spoke the person's language as English was not their first language. People's support plans recorded if they had a gender preference for their care worker. This demonstrated the service respected people's individual preferences.

Some, but not all, of the support plans we looked at contained a life history document. We saw one which provided a summary of the person's life, for example where they had grown up and their professional life. Another person's record detailed what they enjoyed watching on television and who their family members

were. Having detailed information about a person's life enables staff to have insight into people's interests, likes, dislikes and preferences. Life history can also aid staff's understanding of individuals' personalities and behaviours.

The registered person had moved offices approximately two weeks before the inspection. When we visited the office we found staff records were stored on a shelf and not stored securely. Paper copies of people's support plans were also on a bookcase and not stored securely. A digital copy of people's care records was also stored on three portable computer storage devices (USB sticks); the registered person told us these were password protected. When we spoke with the care co-ordinator they told us the USB sticks were not password protected. We visited one person who used the service and they did not know where their support plan was kept. We rang the office of Horizonz Care and they told us the person did not like the records kept in the house and staff kept the records in their car. These examples demonstrate people's confidential information was not stored securely and people who do not have authority may be able to access people's records. This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

# Is the service responsive?

## Our findings

Two of the relatives we spoke with told us their family member had a support plan in place and they were involved in its development. One told us the organisation had recently updated their relative's support plan and posted it to them to review before it was implemented. Another relative told us the care plan for their relative was 'extensive'.

The registered person told us a copy of people's support plans were kept at the office and in people's homes. They said when a new person began to use the service; the care co-ordinator went to meet them and began to implement their support plan.

We reviewed nine people's care and support records. Support plans recorded, where relevant, the time people preferred to receive their support. For example, the time they preferred to get up, eat their meals and go to bed. Support plans also provided details around people's daily activity and the level of support which was needed. One person's plan noted '(person) does not require any help with mobility however they do use a walking stick and a trolley from time to time. (Person) only requires support when they are outdoors'. Each support plan detailed the care and support staff were to provide at each call. One support plan noted '(Person) will bathe independently and once washed, requires support workers to dry their back'. This information ensured support staff knew the level of support individuals require.

The registered person told us people's support plans were reviewed three and six weeks after they began to use the service. When we reviewed people's support plans we saw evidence of regular reviews, however, these documents were computer generated printouts and did not always evidence the signature of the person who used the service and/or their relative. When people sign their support plans and review documentation this shows people have been consulted about the care and support provided for them.

We also noted that where a date for a future review was recorded we could not see evidence this had always been completed. For example, one support plan evidenced a review dated January and February 2015, the date for the next review was March 2015 but there was no evidence this had taken place. Regular reviews help to monitor whether support records are up to date and reflect people's current needs.

People told us they were aware of how to complain and how to contact the registered person. We spoke with one relative who told us they had telephoned the organisation that morning to complain about the service. Another relative said they had raised concerns with the registered person and told us "Some things improve, other things we tell them about often." A person who used the service said they had had meetings with their social worker and the organisation during August 2015 to discuss their concerns. They also said they had asked for someone from the office to come out and observe staff but they said they were told "I don't have time to come out". Another person told us that either they or their relative contacted the office if they were unhappy with any aspect of the service. They said they had raised a concern with the organisation previously and the response had been, "We'll have a word with the girls." Another person also told us when they rang the organisation to complain, "I get a standard response, 'they'll have a word with the girls'."

When we visited one person's home they showed us the welcome pack given to them by the organisation. This included information on how to complain and a complaints form for them to complete in the event they wished to formalise their concerns.

We asked the registered person if there were any current complaints being dealt with. They said there were no formal complaints at present, although there had been one informal complaint. We asked if complaints were logged and analysed, the registered person said they were not.

This evidence demonstrates people were provided with information on how to raise a concern and people regularly raised concerns with the organisation. However, this also demonstrates that these concerns were not formally recorded or investigated and there was no evidence to support that changes were made to reduce the risk of the concern reoccurring.

This evidence demonstrates a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service well-led?

## Our findings

The registered provider was also the registered manager of the service. They were involved on a daily basis in the day to day running of the organisation.

During our inspection of the service we found there were insufficient systems of governance in place and a lack of oversight of the quality of the service delivered from the registered person. The regulatory breaches highlighted in this report evidenced that systems and processes were neither effective nor robust. For example, risks to people were not thoroughly assessed and documented, medicines were not managed safely, there were poor recruitment procedures and staff employed by the service had not received thorough induction, training and supervision.

People were not safeguarded from the risk of abuse. During the inspection we found evidence of potential harm and abuse to service users which had not been reported to the local safeguarding authority or to CQC. There was no evidence the issues had been thoroughly investigated or any actions taken to reduce the risk of a further occurrence.

On the day of the inspection we were not provided with any evidence that audits were completed to ensure people received a service that was safe, effective and compliant with all regulatory requirements. The registered person told us audits were completed by the care co-ordinator and the senior support worker, they were then were saved on a USB. When we spoke with the care co-ordinator they said they did not complete any audits. We were given a copy of the contents of the USB but we could find no evidence of audits on the contents of the USB.

The organisation had moved offices at short notice approximately two weeks before the inspection. We asked the registered person if they had contacted their insurance company to notify them that the business was operating from a different address. They said they had not. This meant there was a risk that in the event of a claim being made of the registered person's insurance, they would not have been adequately protected. We advised the registered person on the day of the inspection about the need to notify their insurer about their change of address. Later that the day the registered person told us they had contacted their insurer and their details had been updated.

The registered person told us regular checks were made on staff performance, these were recorded in service user files. The care co-ordinator told us all staff were spot checked in September 2015 and the records were kept in a file. Later in the day the care co-ordinator told us they were filed in individual service user files. We looked at nine service user files but only saw evidence of one staff performance check. This meant there was poor evidence staff performance was monitored and recorded in a robust way to ensure safe practice.

The care co-ordinator told us questionnaires were sent to people who used the service and/or their families in 'September or October 2015'. We looked at nine people's files but only saw evidence of one completed feedback form. Whilst we saw the feedback was positive, the document was not dated. This meant there

was poor  evidence to support that the registered person had gained feedback from people who used the service.

The registered person told us regular staff meetings were held. When we spoke with support workers they also said they attended staff meetings. On the day of the inspection we were not provided with any record of the dates of these meetings, the attendees or the topics discussed. The care co-ordinator told us no record was kept of these meetings. Staff meetings are an important part of the registered person's responsibility in monitoring the service.

We found people who used the service were not protected from unsafe or inappropriate care as the quality of services provided was not appropriately assessed and monitored. This evidence demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The registered person had failed to notify the Commission without delay of allegations of abuse or harm in relation to a service user; |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>People who used the service were not consistently treated with dignity and respect. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The organisation was not acting in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Risks to people's welfare had not been robustly assessed and relevant risk assessments had not always been implemented. Staff had not been assessed to ensure they were safe and competent to administered peoples medicines. Records relating to peoples medicines were inadequate. |

| Regulated activity | Regulation |
|---|---|

| | |
|---|---|
| Personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>During our inspection we found people were not adequately protected from the risk of harm or abuse. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>Complaints were not formally logged, investigated or acted upon. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff were insufficient and were not suitably qualified, competent, skilled and experienced. |

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 17 HSCA RA Regulations 2014 Good governance<br><br>The organisation did not have an effective or robust quality assurance and governance system in place to drive continuous improvement. |

**The enforcement action we took:**

Warning Notice

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>Recruitment practices were not robust. |

**The enforcement action we took:**

Warning Notice