Carepath Recruitment Limited

# Carepath Recruitment Ltd

## Inspection report

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## Ratings

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

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

# Summary of findings

## Overall summary

We inspected this service on the 20 and 21 April 2017. We also attended the office on the 24 April to provide feedback to the registered manager. The inspection was announced to ensure the provider had someone available in the office to assist the inspection team.

Carepath Recruitment Ltd is a domiciliary care agency. The agency provides personal care to service users in their own homes. The service supports both children and adults with varying degrees of support needs. The agency is located in the town centre area of Preston, close to the town's bus station. The office space is shared with the other part of the business which is a recruitment agency.

At the time of the inspection there were nine service users receiving support from Carepath Recruitment: four children and five adults. Following the last inspection a voluntary agreement had been made between the provider and CQC to not agree any further packages. It was discovered whilst planning for this inspection, that the provider was supporting three more service users than declared at the last inspection and had agreed a further two since the last inspection. The provider had been asked directly via email the service users they were supporting and again did not declare all of the packages.

On the day of the inspection the provider, who is also the registered manager was not available to assist the inspection team. The provider had recruited a care coordinator who was available to the inspectors. We asked the care coordinator who Carepath recruitment were providing support too and again not all the packages were declared. It was only when names were given to the care coordinator it was confirmed the service users were being supported. When we discussed this with the provider and registered manager, we were told, it was a mistake and they thought the commission meant for them to only declare the services the commission were aware of. Following this inspection an urgent Notice of Decision was served onto the provider to ensue no further packages of care were agreed and that the current packages did not increase in hours.

The service was last inspected in August 2016 where six breaches of the regulations were found. The home was rated as inadequate overall and placed into special measures. The key questions of safe, effective and well led were previously rated as inadequate, responsive and caring were rated as requires improvement. At this inspection we found the quality of provision had further declined and the key question of responsive was now also rated as inadequate, with caring remaining as requiring improvement. At this inspection we saw some improvements had been made to some of the regulations and one breach to Regulation 10 was now met. However we noted continued breaches to five of the regulations and breaches to four further regulations. We also judged the provider to be in breach of one of the registration regulations.

There was a registered manager in post. 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 had legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of this and the previous

inspection the registered manager was also the sole director for the registered provider.

At this inspection we found some improvements had been made to some areas, namely at the last inspection there were no care plans for some service users in receipt of support. We found care plans had recently been completed for all service users being supported but we were concerned about the quality of those care plans. At the last inspection staff told us, they did not receive support or supervision. It was clear the new care coordinator had begun to undertake supervisions with some of the staff. When we spoke with staff we were told these were arranged when there was an issue or when they went into the office, time would sometimes be taken to complete supervision. We could not see a definitive timescale for the expectation of supervision but they had begun which was an improvement from the last inspection.

At the previous inspection we found that service users were not involved with the development of their care plans and did not influence the support they received. At this inspection we found that review meetings had begun and they included any concerns the family or service user had shared with the provider. However they were not structured and had only begun in the last month prior to the inspection so the impact of these could not be seen. We did not note any changes to service user's care plans as a result of the reviews.

As at the last inspection we found risks and service user's support needs were not always assessed appropriately. We found the same at this inspection. Medication risk assessments were simply a list of the medications rather than an assessment of the risks associated with the person taking or not taking the medication. There was no person centre information in the assessments to determine any risks with any aspect of service user's medication. We found other risks which were identified within initial assessments or daily records were not assessed and plans of care were not developed to support service users with their specific needs.

Medication was again poorly managed and various gaps in the MARs (Medication Administration Records) were evident. These were not picked up via audits and the reason for the gaps was not explored. This could have meant service users had missed their medication.

At this inspection we visited the property of one of the children in receipt of support and three of the adult packages. In all the homes we visited we found contradictory information within the care plan held in the office and the one held in the home. Service users were not protected by up to date, appropriate and reflective care plans and assessments.

We found other areas of service delivery had not changed since the last inspection including poor audits of the service provided and a lack of collation of accidents and incidents to identify themes and trends. This would enable the service to reduce any identified associated risks.

There was not any evidence at this or the previous inspection to support the implementation of the Mental Capacity Act 2005. We were aware of service users who were restricted in their daily activity and applications had not been made to the court of protection to ensure this was done legally. We were also aware of service users who did not have the capacity to make informed decisions or give consent and the service had not assessed how to best support these service users.

We found staff had not all received appropriate training for the role they were undertaking. Supervision had recently begun, but there were no systems in place to test the competency of the staff. This was in respect of their duties including moving and handling, medication administration and the management of more complex needs. We had concerns in all three of these areas.

Staff were not recruited safely. Whilst we saw appropriate checks via the DBS, we noted references were not validated and some application forms held miss information that was not identified and assessed, to determine staff suitability to their role.

We were told by staff that things had recently improved and whilst the care coordinator told us some staff were now on permanent contracts, in the five files we reviewed all staff remained on zero hours contracts. Service users we spoke with, spoke well of the staff and staff we spoke with appeared motivated to complete their role as well as they could.

We discussed at length the requirements of the regulations and the need for robust systems of quality audit to drive improvement. At the last inspection concerns were noted and the provider was informed of what was required to address the issues. The provider had developed action plans for the breaches noted within the report. Areas of a higher concern had been detailed within other correspondence to ensure the provider made improvements with the service. We found the provider had not taken the steps, they had identified as required within the action plans, presented to the commission to address the identified breaches. This included the completion of capacity assessments for all service users using the service, supervision of staff who had made errors on medication records and staff administering medication to have their competence checked. Omissions also included; the inclusion of family and service users using the service in development and review of care packages and that service users could choose their care worker. No one we spoke with confirmed that this happened.

We found steps had been taken to better support one person in a more dignified and respectful way, but we still had concerns about the management of this package. A robust system of quality audit had not been developed or implemented. Without this it is clear improvements could not be measured by the provider. We continued to find the leadership of the organisation was not engaged with the delivery of registered activities and the regulations that underpin them.

We found continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were namely around; safe care and treatment, need for consent, good governance, person-centred care and staffing. We also found additional breaches in respect of managing complaints, safeguarding, the recruitment of staff and a failure to display the last inspection ratings. Breaches to the registration regulations were also noted in respect of the submission of notifications.

The overall rating for this provider remains 'Inadequate'. This means that it will remain in 'Special measures' by CQC.

The purpose of special measures is to:
Ensure that providers found to be providing inadequate care significantly improve.

Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements had been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their

registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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.

The provider had not considered how the service would continue in the event of an emergency. Staff supporting vulnerable service users in their own homes had not been trained in how to handle emergency situations.

Staff had not been recruited in line with regulations. References were not validated and where risks to the suitability of staff were identified they were not managed, to ensure safe recruitment practices were followed.

Where risks to the health and welfare of service users in receipt of support were identified, the provider did not effectively assess or manage these. Safeguarding procedures were not followed and only one of the staff on the rota, had evidence of any training in this area, in the last 12 months.

Service user's medication was poorly managed. We saw medicines were not checked in, stored, recorded or administered in line with best practice guidance and regulations.

### Is the service effective?

**Inadequate**

The service was not effective.

We saw when service users had specific health care risks they were managed through healthy eating and medication; but specific professional care plans were not followed.

Service users were not supported by the Mental Capacity Act 2005. Service users were unlawfully restricted and their needs were not assessed, when they were unable to consent to support.

There was a dedicated suite of e-learning; it was not clear what was mandatory and what was optional. There was no evidence to show over 50% of the staff had completed any of the training.

Some staff had received one supervision session since the last inspection but there had not been any team meetings.

## Is the service caring?

**Requires Improvement**

Some aspects of the service were not caring.

Service users were not always involved with developing and reviewing their care plan in an effective way.

Steps had been taken to better preserve the dignity of service users but this impacted on other aspects of their support needs.

We saw some service users were given choices by staff in their day to day routine.

## Is the service responsive?

**Inadequate**

The service was not responsive.

Plans of care were task focused and needs were not assessed and managed appropriately

We noted service users were involved with different activities.

The service was not following its own complaints procedure and complaints received, were not investigated or managed, to reduce risks or re-occurrence.

## Is the service well-led?

**Inadequate**

The service was not well led

The provider did not have an effective or comprehensive set of quality audit and assurance tools. This left, failings to meeting the regulations unchecked.

Risk assessments for the safe management of care packages had not been developed.

A set of policies and procedures were in place but they were not followed or implemented in the service.

# Carepath Recruitment Ltd

**Detailed findings**

## Background to this inspection

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

The inspection was prompted in part, to gain an updated perspective on the quality of the service, in line with our enforcement procedures. The inspection also took place, as the service was rated inadequate overall and was placed into special measures, at the last inspection. As such, it is the commission's responsibility, to ensure provision has not worsened and further enforcement action is required, to keep service users in receipt of support from the service safe.

This inspection took place on the 20 and 21 April 207 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in to support the inspection.

The inspection team consisted of two adult social care inspectors. Prior to the inspection, the lead inspector reviewed the available information the commission held on the service, including reviewing the last report and any outstanding actions. We requested any intelligence from our stakeholder group, including the Local Authority and local health watch team.

During the inspection, we reviewed the records the staff used to guide them, in supporting the service users using the service. This included, reviewing the medicine administration records for three service users, one of whose home we visited.

We spoke with the registered provider and registered manager, the care coordinator and five carers including a senior carer.  We spoke with four service users and reviewed seven service users' care plans. Four service user's plans were reviewed both within the office and within the person's own home.

We also looked at five staff personnel files, reviewed the service's training information and assessed the suitability of recruitment information. The service's policies and procedures were reviewed to ascertain their

implementation by the service's staff.

Inadequate

# Is the service safe?

## Our findings

It was difficult to gauge the service user's view, on whether they felt safe, due to either difficulty with their understanding or language barriers. One person perceived themselves as being safe and told us they got on very well with their carer. This person told us, they fell down the stairs a lot and they were due to move to new accommodation, to better support them and reduce the risks associated with stairs. However, this risk had not been assessed and was not recorded within their care file.

We observed staff interactions, with service users using the service, on two occasions. We had concerns in the observations we made. It was clear in one circumstance, the carer was not aware of some of the support needs, of the person they were supporting. These needs required careful assessment to protect both the service user and staff member. We spoke with the provider and registered manager about this, who assured us they would ensure the appropriate assessments were undertaken. The second observation was also a concern. We noted a service user who had a specific care plan, to support the risk of choking, was not being appropriately supported. The care plan clearly stated the person should be given drinks in a lipped cup. We saw the staff member supporting the service user with drink from a glass. Both of these observations highlighted to us that service users were not safely supported.

We noted the service had a comprehensive safeguarding policy which clearly identified when circumstances required reporting to the safeguarding team. This included unwitnessed injuries and aspects of neglect. We noted from records we reviewed in one home that the service user had a number of unknown injuries. Staff had assumed this was as a consequence of the equipment they were using and assured us this was being addressed. However, the service were not following their own procedure, in how the injuries were recorded and monitored. We also noted a situation where a staff member had fallen asleep and a service user had got out of their flat unsupported. This service user required one to one support. We specifically asked the service to report this as a safeguarding alert, at the time of writing this report it had still not been done. We were assured by the care coordinator that the staff member was to be dismissed and the risk would be managed.

We reviewed the available training information provided to us and found, that only one of the staff out of the 17 on the rota provided to us, had a record of receiving training in safeguarding.

The senior carer we spoke with had a good understanding of basic safeguarding and had completed the training. However, they had not implemented the procedure, when the service user they were supporting, had unexplained injuries. We also discussed restrictive practice with them and noted where this was used appropriate assessment had not been completed. The specific needs of the service user they were supporting were identified during discussion. The senior carer acknowledged the lack of appropriate assessment to ensure their needs were met in a lawful and respectful way.

Following the inspection, the CQC raised two safeguarding alerts which are currently being investigated by the local authority. We had concerns around the ongoing safety of service users receiving support from the service and have taken steps to ensure immediate improvements were made. We have found the service in breach Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the available assessments the staff and service used to ensure service user's needs were met. We found there was a lack of current assessment, to the health and safety of service user's living environments, including the use of equipment. An initial assessment had been completed for some service users, when they first accessed the service, but these had not been updated and others had nothing. We saw one risk assessment had a date on it of 13 March 2017; however, it clearly described circumstances and risks which were not assessed at that date. This included the use of equipment for the service user, two years prior to the assessment. There was also detail within the assessment which stated the parent of the service user was expecting a baby, which they had been five years prior to the date of the assessment. This led is to question the accuracy of the assessment.

We also noted that assessments did not include any details of contingency or managing of emergency situations. We discussed this with one senior carer who clearly stated they would not know what to do in the event of a fire or an emergency situation. We found the service to be in breach of Regulation 12 (1) (2) (i) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We found assessments had not been completed on identified risks including, falls, food allergies, diabetic management, mental health needs and use of a hoist. We found these risks were unmanaged and not monitored. This increased the potential risk to service users using the service. One person had a diabetic care plan completed by a specialist diabetic nurse. The plan clearly showed staff how to support the person with their diabetes. This included monitoring their condition and taking certain action when risks presented. The plan clearly stated staff should contact the person's GP in certain circumstances for further advice. What we found on the day of the inspection was the staff were simply providing the person with over the prescribed amount of insulin to manage their blood sugars. The CQC raised a safeguarding alert to ensure this person was kept safe.

We found the service did not take appropriate and effective action to risk assess service users safely and then follow plans to mitigate and reduce risks to service users.

Where service users had accidents or incidents they were not always recorded and were not managed appropriately. There were no collated central record of accidents and incidents. This meant that the service management team could not identify any themes or trends and take action to reduce risks. We noted the paperwork for one incident was only given to the management three weeks after the incident. This led to a delay in the management reacting appropriately to the incident. We discussed this at length with the care coordinator and agreed a better system needed to be implemented. We discussed either a text or call system being developed so incidents and accidents of a certain nature were immediately reported to the office. A lack of appropriate and effective risk management meant the service was in continued breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

On the day of the inspection we did not observe any of the staff administering medication. We looked at the available records in two of the service user's files in the office and in one of service user's homes. At the last inspection in August 2016 the service were found in breach of the regulation associated with the safe management of medicines. The provider had provided the Commission with an action plan following the last inspection. We reviewed the action plan and found the planned actions had not been implemented. Within the action plan, the provider described how they would ensure staff were competent in administering medication, by training and direct observations. This has not happened. The provider asserted that each service user would have a medication risk assessment and medication care plan. We found the risk assessments were simply a list of the medications the service users took, with no detail of any identified risks, associated with taking the medication. The risk assessment didn't identify specific risks for the identified medication or the person who was prescribed it. The action plan went on to say, how the

management of medication would be audited and how any errors would be managed. None of the provider's action plan, developed to meet the requirements of the regulation, had been implemented appropriately.

In the records we looked at we saw gaps with no indication if the medicine had been taken, been refused or been destroyed. We found handwritten MARs with no validation of their accuracy by a second staff member. We found the prescriptions were not always followed and GP's were not contacted for professional support, when there were concerns with service user's medications. We found the dosage administered was not recorded when the prescription identified a maximum dose. We found medicines were not stored appropriately. We were told on the last day of our inspection that a whole delivery of one service user's medication, had gone missing.

The service's medicines policy and procedures were not being implemented and there was not a PRN protocol or homely remedies protocol. The management of medication was not being audited to identify and rectify errors and problems. We found the service was in continued breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act (Regulated Activities) Regulations 2014

At the last inspection the service was found in breach of Regulation 18. This regulation ensures there are enough suitable staff, on duty, to meet the needs of service users. We found the service user who required two staff available to hoist them, still only had one member of staff on duty at different times of the day. The provider told us the reason for the service user to be hoisted had been managed by different means and therefore only one staff was required. We discussed this at length. The service user wanted the support of two staff more frequently than was provided by the service. When a service user requests something that is not given and they do not agree or understand the rationale for the denial of the request, it is called restrictive practice and can constitute abuse. Where the service user lacks capacity to make an informed decision, this should be assessed and if appropriate a best interest decision made with the appropriate professionals. In this incidence an assessment had not been completed and there were a number of incidents where the service user had become distressed requesting the support of two staff. This was found to be a continued breach of Regulation 18 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

On the day of the inspection we were told by the care coordinator there were 18 staff working for the service. We asked to see the personnel records for five of them. We reviewed the personnel file for the care coordinator, one senior carer and three carers. We had concerns with all of the recruitment files we looked at. We found two of the five applications did not include a full work history with large blocks of time missing. In one application this was as much as 20 years. One personnel file did not hold a record of an interview and two had a contract start date prior to the receiving of a DBS check.

We noted the care coordinator had an application and contract for a carer from May 2015. However, they were now working as a care coordinator. We asked to see the recruitment documentation for their current post. The registered manager provided us with a step by step process for their recruitment, but was unable to produce any documentation, to show it had been followed. The final point on the process was that a contract would be issued, within two weeks of starting post, but no contract was available.

We looked at the application forms in detail and found that one staff member had not declared criminal convictions, which were recorded on their DBS. We discussed this with the registered manager and provider who was unaware of this. A risk assessment had not been completed to ensure the person was suitable to work with vulnerable service users. We found criminal convictions recorded, on two other DBS certificates we looked at and again found there was not a risk assessment completed, to ensure they were also suitable

for their role.

We looked at the available references for all five staff whose personnel files we reviewed. We found a number of discrepancies. This included one staff member not having any references on file and another only having one reference. Two references had been completed by current staff at Carepath recruitment and two references contained false information. We contacted the company that had allegedly provided the reference. We were told, the reference had not been completed by anyone at the office with the authority to give a reference. The reference stated the staff member had been known by the signatory of the reference for seven months and on their application form they had said they had worked for the other company for 18 months. We found that the staff member had worked for the other company for approximately a week and had completed a shift and then not got back in touch with them. None of the references we saw were validated as genuine references.

We were not confident the service had followed safe and legal recruitment processes. We raised this with the registered manager and provider and requested they take immediate action to assure themselves staff working at the service were safe. We have found the service in breach of Regulation 19 (1) (2) (b) (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This key question continues to be rated as inadequate.

Inadequate

# Is the service effective?

## Our findings

It was difficult to gauge from service users if they thought their needs were being appropriately met. We discussed this with the parents of one service user. The parents were also receiving support from the service. The parents told us they were happy with the service and liked the staff. However, when we asked to see their files they were unable to provide the file for their child. We were told the registered manager and provider had been to the home that morning and taken the file. This meant the staff supporting the family, were unable to review the recent support provided or record the support, they would provide. We looked in the available files and saw the daily records had not been completed for the previous three weeks.

The information within the personnel files showed us that on two occasions staff had completed their application form, attended their interview, completed their induction and completed some on line training all in one day. This led us to question the quality of the induction and training. We also noted that 10 staff on the rota, were not identified on the list provided to us, to show who had received training.

The service were supporting service users with some complex needs. Staff were administering medication, supporting service users with diabetes and complex personal care needs including catheter care. We reviewed the available training in these areas and found that the service were using an online training provider. We were not assured the available training was enough to ensure the competence of staff in these areas. We discussed the basic training package with the training provider and were told, the courses were provided with an assumption there is already a knowledge base. Courses did not contain any practical elements and the provider would need to ensure staff were signed off, as competent, in the areas they were trained in.

We asked the staff we spoke with whether they had received any competence testing in medication and were told no. We asked if they received competency testing in any aspects of care and support they provided and were told no. Some training had been provided by specialist teams including catheter care. We reviewed the management of medication, management and support of diabetes and catheter care. We noted gaps and errors on the medicine records, the care plan for diabetes support was not being followed and the records to support the service user's fluid input and output were poorly completed.

We raised a safeguarding around the poor support provided to someone living with diabetes. It was noted by the investigating social worker that staff knowledge was poor. The diabetes nurse was to supply urgent training to the staff supporting this person, to ensure the person was kept safe, moving forward. We found the staff supporting service users did not all have the competence, skills and training they required to do so safely and effectively. This meant the service was in continued breach of Regulation 12 (1) (2) (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We spoke with staff around the support they received and all told us it had improved since the new care coordinator had come to post. We saw that supervisions had begun to take place but that they were mostly reactive and were not scheduled. This meant that staff were not aware of when they could expect supervision. However, we were told they could ring the office and get support over the phone if it was

required. We noted from one supervision record that the staff member had identified the training was an issue. One carer, who supported a vulnerable service user, was doing so, without key knowledge around the risks associated with the support required. We discussed this with the registered manager and were assured the staff member would receive appropriate supervision. The supervision was to ensure staff were competent in supporting the service user whilst keeping both themselves and the service user safe.

Annual appraisals had not taken place and there was no record of any historic appraisals. Staff told us they had not received any competency testing in any of the clinical support they provided. Only one team meeting had been held since the last inspection and only office staff were in attendance. The minutes and agenda were available but they were not a record from which the discussion details could be gleamed.

We noted two incidents where action had been recorded as required by the care coordinator to improve staff performance. In one of these incidents the staff member was to complete three training modules by the 31 March 2017. There was no evidence they had been completed. We asked the staff member what training they had done recently. The staff member confirmed they had completed the two courses, as identified on the training list, provided to the Commission. The three courses required by the care coordinator had not been completed. It was also noted, the staff member was not to work with the service user again for a while. Yet the rota did not show a break in the work cycle of the carer and the service user. A lack of appropriate training, lack of scheduled supervision and appraisal and inconsistence performance management meant staff were not effectively supported to fulfil their role and is a breach of Regulation 18 (1) (2) (a) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of service users who may lack the mental capacity to do so for themselves. The Act requires that as far as possible service users make their own decisions and were 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.

Service users can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

At the previous inspection in August 2017 we found the service in breach of Regulation 11, Consent. The provider and registered manager submitted an action plan to the Commission which identified the actions, they concluded were required, to meet the requirement of the regulation. This included the completion of mental capacity assessments for all service users. Where that assessment identified, a service user to have fluctuating capacity, they were to be supported with decision specific assessments. Best interest decisions were to be agreed with appropriate professional involvement and used to support the service user. At this inspection we found the provider had not completed any of these actions. We noted consents had not been gathered from any service users for any activity since the last inspection. One service user who was restricted from undertaking certain activity, continued to be restricted without appropriate assessment. We also noted two service users were restricted by lap belts without assessment or appropriate consent.

One service user who lacked capacity was restricted in their daily activity. The care package was complex and the Local Authority were aware of the need to apply to the Court of Protection to support this individual. The Commission raised a safeguarding alert to ensure this person was legally supported moving forward.

We discussed with the staff we spoke with the principles of the Mental Capacity Act and as at the last

inspection their knowledge was limited. We noted from the training records we looked at that four staff had completed training in the last six months. There were no earlier records provided for us. We were told some service users, had people and family who represented them through power of attorney, but there was no evidence collated by the service to support this. We found the provider had not taken the required steps to meet the requirements of this regulation and remained in breach of Regulation 11 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

We looked at the available records to support one person with their eating and drinking. An appropriate referral had been made to the Speech and Language Team (SALT) to identify the steps the service should take to support one person with a risk of chocking. We saw from another service user's Local Authority assessment that they had a recorded mushroom allergy which had not been recorded elsewhere within their care plans. We recommend the staff were all made aware of each service user's support needs and plans of care were developed. Where they were developed we recommend staff agree when the identified risks present themselves and consistently follow the plan.

Service users we spoke with looked well-nourished and told us they liked the food the staff helped them to prepare. We were told they were supported with their shopping and staff encouraged them to purchase healthy and nutritious food.

One other service user told us of the how the service had supported them to get involved with a local gym programme to help them manage their diabetes.

The service worked with local district nurses, diabetic nurses and social workers. The quality of how the service implemented the support offered is addressed in other areas of this report.

The rating for this key question remains as inadequate.

Requires Improvement

# Is the service caring?

## Our findings

Service users we spoke with told us the registered manager and provider asked them if they were ok. One person told us, "[registered manager] was here today checking we were ok." Another person told us, they liked the registered manager and understood that she could complain and they would change things for them.

When we were visiting one person we looked at their daily records. Whilst they hadn't been completed for the three weeks prior to the inspection, we noted that they were taken out regularly and were supported to attend weekly mosque. This was important to them and the service ensured someone was available who could escort the service user each week.

At the last inspection, we did not see any evidence to show us that service users were involved with the development of their care plans. The provider and registered manager had sent us an action plan, stating three monthly review meetings would be held, with the family and service user if appropriate. We saw some records of these. Notes were not of meetings that service users or their relatives attended, but were a note to incorporate any concerns or issues highlighted by service users or their family. A response from the service was recorded as to how they were going to make improvements. This wasn't a direct review of care or the care plan, but was a step in the right direction to ensure service users or their family, had an avenue to influence the care they or their loved one received.

Service users we spoke with identified good relationships with the staff that supported them. One person told us there had been some recent changes in staff. We asked if they had been given a choice of who was to support them. The provider and registered manager had identified within the action plan provided to the CQC, that this would happen, following the last inspection. They told us they had not been given a choice but were happy with the new staff and said they got on with them well.

At the last inspection we found the service were not preserving the dignity of one service user. At this inspection we saw steps had been taken to manage the situation better and relevant professionals had been involved with decision making for this person. The service were no longer in breach of the regulation. However, we recommended further steps were taken to ensure appropriate assessment of this person's needs, in the preservation of their dignity, were undertaken. This would help ensure they were always treated with respect.

Service users who we saw were receiving support with their personal care needs looked clean and well presented. One family's house we visited was receiving support for each of the three members of the family with differing support needs. We saw the agency were also providing support to the family with their domestic duties and house cleaning. We sat in the main living area while we spoke with the parents in the family and found the room was clean and tidy.

Staff we spoke with were aware of the service users they supported likes and dislikes. One staff member clearly described, the action they would take to ensure the service user they supported settled, if they

became upset whilst in receipt of support.

The rating for this key question remains as requires improvement

Inadequate

# Is the service responsive?

## Our findings

In two of the service user's files we reviewed we saw steps had been taken to find out their likes and dislikes. This included information about what one person liked to eat and where their food shopping should be purchased. The other included details of how they liked to spend their day and what was important to them.

However we also found that other plans had not been updated as service user's preferences changed. One person's activity care plan identified them as enjoying gong to coffee shops. The daily records stated that the person now preferred not to leave the house.

At the previous inspection in August 2016 the service was found in breach of Regulation 9 which addresses person centred care. The provider and registered manager had submitted an action plan to the Commission, stating what they would do, to meet the requirements of the regulation. During this inspection we ascertained that most of the action plan was still to be implemented.

When reviewing service user's care plans we noted they were not holistic packages for care but predominantly task focused plans to meet service user's identified needs. The provider and registered manager identified within their action plan, that all packages of care would be set up and then be reviewed and agreed with the family and where possible with the commissioning authority, as appropriate. This had not happened. Everyone using the service now had a care plan as previously this was not the case. But, most of those plans had only been developed the month prior to the inspection and all did not include the detail to safely support service users. Others plans which had been in place had not been updated since September 2016. A comprehensive risk assessment was completed for one service user that was dated March 2017. However, upon reading the assessment it was clear it had been written much earlier as had references to events which took place in 2012.

The provider and registered manager's action plan provided following the identified breach to Regulation 9, also stated that all care plans would be audited each month, to ensure the information within them was current and appropriate to the needs of the service user. This had not happened, except in one case, which did not identify the need to update one service users care plan, after their social and recreational needs had changed.

We found contradictions within care files, including if service users needed drinks thickened or not. We also found inconsistencies between what care the care coordinator told us service users needed and what was recorded in their files. For example, we were told one package was simply a domestic package and when we looked at the file; staff at the service were supporting them with personal care and emotional support. The service user had fallen a number of times but there was not a plan in place to show how the service was supporting them with this.

We looked at files within the office and within service user's homes. We found when plans of care had been developed with external professionals to meet specific and complex needs these were not always being

followed. When the Local Authority had commissioned packages of care and completed an initial assessment, these had not been developed into comprehensive packages of care. We found inconsistencies and contradictions in plans put service users at risk of not receiving the care and support they needed to keep them safe. This is a continued breach of Regulation 9 (1) (2) (3) (a) (b) (d) of the health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

We asked the care coordinator and registered manager and provider for the complaints information and was told there was none. We were told the service had not received any complaints. We were aware of three complaints which had been shared with us as part of the inspection. One service user told us of a complaint which they thought the registered manager and provider dealt with appropriately. Another complaint, was recorded in a three monthly review around there being too many staff on a package and the mother would prefer it if it was just one or two. The same person also raised concerns around their family member's routine not being followed. There was no other detail recorded to ascertain how these were concluded. A professional also identified a further complaint which the manager and registered provider said they had no knowledge of until we raised it with them.

A complaints procedure was available in the service's policy folder. We asked service users using the service if they received any information from the provider when they first began using the service including details of how to complain and were told no.

A lack of a system and procedure to deal with concerns and complaints is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The rating for this key question has changed from requires improvement to inadequate.

Inadequate

# Is the service well-led?

## Our findings

The registered provider is currently the registered manager. The commission are in the process of taking enforcement action which can be published at a later date. The provider has also been asked to source a suitable candidate to support them with the day to day management of the service.

The provider had employed a care coordinator but we were unsure of their suitability due to the details of their recruitment. Both the care coordinator and provider had not declared information with the Commission upon request. This has led us to question the suitability of the registered provider and care coordinator.

We asked the care coordinator about staff meetings and were given the minutes of one meeting held on the 6 and 27 March 2017. The meeting was for office staff only and one had not been held for the carer staff in the company. The minutes identified another meeting to take place one month later.

Staff we spoke with told us they received better support now the new care coordinator was in post and we could see some supervision had been completed. However, these were not scheduled so staff did not know when to expect them. Appraisals had not been completed with any of the staff. The service still lacked oversight but some steps had been taken in attempt to improve this.

The service had a set of policies and procedures. However, when we reviewed these for the service's safeguarding procedures, complaints procedures, recruitment procedures, quality audit procedures and medicines management, we found they were not being followed. There was no formal route for staff to be informed of the service's policy and procedures including any new procedures as they were introduced.

We found when incidents occurred, they were not investigated completely and findings and learning from them was not shared with the staff team or the service users involved, in a timely manner. This included consequences of actions by staff including falling asleep on duty and allowing partners without the appropriate checks and safeguards into their place of work with vulnerable service users.

We raised a safeguarding alert for one service user around the monitoring of their diabetes. Their care plan clearly said their GP should be contacted in the event their blood sugar levels went above a certain rate. The sugar levels had been consistently above the recommended rate and the care plan had not been followed. The safeguarding social worker contacted the GP who was unaware of any concerns and organised a Multi-Disciplinary-Team (MDT) meeting to agree how to keep the service user safe. This included urgent training by the diabetic nurse for the staff supporting the service user.

When services do not have clear systems, to ensure staff have access to the information they need to safely complete their role, there is a risk staff will act on their knowledge of situations, rather than on the shared procedures of the service. When risks had been identified and staff had not been given the information to support service users exposed to that risk, there was a risk of reoccurrence or of risks not being effectively managed. When plans of care were not audited to ensure they were being followed there was a risk service

users would not get the support they needed to keep them safe. This is a breach of Regulation 12 (1) (2) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Under the registration regulations the Commission should be notified of incidents of serious injury, suspected abuse, police incidents and other named incidents. The provider had not informed the Commission of incidents of serious injury or suspected abuse. This is a breach of Regulation 19 of the Health and Social Care Act (Registration) Regulations 2009.

At the last inspection in August 2016, we found the service in breach of Regulation 17. This regulation identifies, what is required from services, to ensure there is good governance procedures in place. This allows good oversight of service provision and allows the implementations of plans for development and improvement.

Since the last inspection service users, the staff and stakeholders had not been asked for their opinion on the service they received or delivered. This is a key part of effective quality assurance and allows providers a base line for improvement. Carepath recruitment did not have this perspective of the service they delivered.

Quality audit of service provision allows providers to understand what is being completed and delivered and what isn't. It also allows them to ascertain the quality of the records the service holds for the service it delivers. The audits completed by the provider were very limited and not fit for purpose. For example, one audit of a care file stated the detail of the power of attorney for one servicer user was in the service user's file. When we looked in the file, there was a phone number of someone who the provider said was the power of attorney, but there was not any evidence to show this. One medicines audit was simply a copy of a MAR (Medicines Administration Record) it was not dated and did not provide any analysis or detail of the information recorded on the MAR.

Another audit of a care file was presented to us, but this was simply a record of what had been completed on that date, as there was no available file for the service user prior to the date of the audit.

The provider did not have a system of quality assurance and quality audit. This did not allow the provider to ascertain the quality of the service it provided or views of the service users the service was provided too. We found the provider in continuing breach of Regulation 17 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the records the service held to keep service users safe and found contemporaneous records were not available. This included records required to keep one service user safe when their blood sugars were high. Their diabetic care plan clearly stated when records of blood sugars reached a certain level, records should begin to be kept of the service user's ketones levels. These records had not been kept, on any of the five occasions the services users blood sugar levels were above the level required, for the records to be kept. We also found blood sugar levels were recorded on a water temperature monitoring record. Contemporaneous notes were not kept for another service user who fell and did not have the risk associated with them falling assessed or monitored and managed. Contemporaneous records were not kept nor were they available of daily contact with three other service users whose records we reviewed.

When contemporaneous records are not kept there is a risk service user's key information and needs would not be shared with the staff supporting them. This in turn could lead to them receiving inappropriate and unsafe support. This is a breach of Regulation 17 (1) (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A requirement of the provider's registration with the Commission is to the display the ratings of any inspection undertaken by the CQC. Carepath recruitment website for its homecare states the provider is complaint with all of our standards. The ratings from the previous inspection in August 2016 were not displayed on the company website or within the office. This is a breach of Regulation 20A of the Health and Social Care Act (Regulated Activity) Regulations 2014.

The rating for this key question remains as inadequate.

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 provider had not routinely notified the commission of serious incidents or allegations of abuse. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>Service users were not involved with the development and review of the care they received. Service users were not enabled and supported to make decisions about how they received support. Care was not designed to include service user's preferences.<br><br>Regulation 9 (1) (2) (3) (a) (b) (d) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Service users were not protected by staff that had a developed knowledge of safeguarding. Safeguarding incidents were not reported or managed appropriately and in line with the providers own procedure.<br><br>Regulation 13 (1) (2) (3) (b) (c) (5) (7) (b) |

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

| | |
|---|---|
| Personal care | Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints<br><br>The provider did not have a working system for receiving, handling, investigating, managing and responding to complaints. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments<br><br>The provider did not display their ratings from the previous CQC inspection |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>There was not enough staff to meet the needs of service users. Staff did not receive appropriate, support, supervision and appraisal to competently fulfil their role<br><br>Regulation 18 (1) (2) (a) (b) |

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 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider did not have suitable arrangements in place to ensure that consent was gained from service users prior to the delivery of support. Service user's capacity was not assessed to determine if they could give valid and informed consent. Where service users could not give consent due to their capacity, no steps were taken to ensure decisions were made in their best interests in accordance with the Mental Capacity Act 2005.<br><br>Regulation 11(1) (2) (3) |

**The enforcement action we took:**

A section 31 NOD was issued to impose conditions on the provider's registration

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider was not effectively identifying and managing risks to service users. The provider did not take the required steps to mitigate risks once they were identified. the provider did not have plans in place in the event of emergencies. The provider was not safely managing the administration, storage, handling and recording of medication. staff were not suitably competent to undertake the role for which they were employed.<br><br>Regulation 12 (1) (2) (a) (b) (c) (g) (I) |

**The enforcement action we took:**

An NOP was issued to cancel the providers registration

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good |

| | |
|---|---|
| | governance<br><br>The provider did not operate effective systems and processes to effectively assess and monitor the quality of service provision. Regular audits and monitoring did not take place. The provider did not develop systems to gather feedback on the service they delivered. The provider did not hold contemporaneous record in respect of each service user's care and support provided. |

**The enforcement action we took:**

An NOP was issued to cancel the providers registration

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>The provider did not have procedures in place for the safe recruitment of staff. Where records identified risks they were not assessed to ensure staffs suitability to the role. Some records were not validated and were found to be fraudulent.<br><br>Regulation 19 (1) (2) (b) (3) (a) (b) |

**The enforcement action we took:**

An NOD  was issued to restrict admissions and ensure the recruitment of suitable management