Miss Rachel Mary Corrigan

Your Care

Inspection report

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15 August 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 10, 11, 14 and 15 August 2017. The first day of the inspection was unannounced. Your Care is a domiciliary care agency providing care and support for people living in their own homes in the geographical area of Wirral. The provider was registered with the Care Quality Commission for the regulated activity of personal care. The service does not require a registered manager, as it was managed by the registered provider. This was our first inspection of the service since their registration in September 2016.

At the time of our inspection we believe there were 51 people receiving a service from Your Care. The agency was responsible for providing in the region of 120 calls per day.

During this inspection we found breaches of Regulation 9, 10, 11, 12, 13, 16, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found a breach of Regulation 18 of Care Quality Commission (Registration) regulations 2009; failure to notify the Commission of notifiable incidents.

People who required essential care and support to take their medication received an unreliable service. The registered provider lacked oversight of the organisation and was not able to ensure that all vulnerable adults received the calls they needed to meet their needs.

We saw evidence of occasions and people's family members told us that people were left hungry and waited for food, did not receive medication that was essential for their health and wellbeing and people were put into situations where their dignity was compromised.

People's relatives told us that they had made frequent complaints. They said issues were not resolved; communication when raising issues was poor and they did not feel listened to. One person's family member told us, "Their communication was absolutely diabolical, the worst ever."

We found that staff rosters were poorly planned and staff members were deliberately double booked at up to five places at once; this is referred to as 'call cramming'. This meant that it was impossible for people to receive their care when it was needed. It was inevitable and obvious to the registered provider that people would be forced to wait for their care for hours without any explanation or warning.

The process for assessing risks to people was poor. The service did not have an effective risk screening process in place to identify and mitigate the risks associated with people's care needs. This lack of assessment meant that significant risks in people's care had not been highlighted or addressed. There were many examples of serious omissions that meant that staff members did not have access to essential information needed to care for people safely.

The registered provider had no oversight of risks or the risk assessment process within the agency. This

placed people at unnecessary increased risk of avoidable harm.

The processes for ensuring that staff that had been recruited were suitable for the role of working with vulnerable adults were inadequate and incomplete. We looked at the staff files for seven staff members. We saw that the registered provider had failed to complete their obligations to ensure that people employed were suitable and of good character for all of the seven staff files we looked at. For recently recruited staff members the registered provider had also failed to obtain a disclosure and barring service (DBS) check. A DBS check looks at any criminal records a person may have and checks to see if people have been placed on a list barring them from working with vulnerable adults. The registered provider had not taken steps to ensure that people employed were fit and proper persons for the role. This placed vulnerable adults at risk.

There was no evidence that staff had been inducted into their role or received appropriate support. We saw no structured method being used by the provider of assessing the performance and suitability of staff in their role of supporting vulnerable adults.

The registered provider did not appear to be aware of the seriousness of their lack of oversight and the significant risks this posed to the people relying upon the service for their care. It is by chance that this combination of a lack of oversight of the service, inadequate records, inadequate risk assessing, inadequate rostering, unsafely recruited care staff, missed calls and missed medication had not led to a vulnerable adult suffering significant harm.

On 22 August 2017 CQC used its urgent powers to keep people safe.

The provider has 28 days to appeal against this action to the First Tier Tribunal (Care Standards) under section 32 (1) (b) of the Health and Social Care Act 2008. Once this period has passed, the action will be reported upon.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC.

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as

inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The registered provider lacked knowledge and oversight of the safety of their service. Inadequate processes and lack of staff training meant that vulnerable adults using the service were not safeguarded from neglect and abuse. If issues did arise they may not have been appropriately reported and acted upon.

The service was not reliable. Calls to provide essential care were being missed. This placed vulnerable adults at risk of harm.

The service was not reliable in administering people's medication. Recording of medication administered was poor and left people's health and wellbeing at significant risk.

The methods used for recruiting new staff were unsafe. The registered provider failed to ensure that staff being employed were suitable to work with vulnerable people.

The system in place for assessing risks to people was inadequate. The service did not have an effective risk screening process in place to identify and mitigate the risks associated with the people it supports.

The service did not have sufficient staff employed to care for people's needs safely.

Is the service effective?

Inadequate

The service was not effective.

The registered provider was not able to show us any records to demonstrate that they provided their staff members with the training that is necessary for them to be effective in their role.

There was no evidence that new staff received any induction or shadow period to introduce them to the people cared for and ensure they were suitable for the role identified.

There was very little evidence of ongoing support for staff.

Inadequate consideration had been given to obtaining people's consent for their care or respecting their rights to choice and making decisions.

Is the service caring?

Inadequate

The service was not caring.

Some people's relatives told us that individual staff members had a caring approach. However the systematic lack of attention to the care needs of vulnerable adults meant that the service was not caring towards people.

The unreliability of the service put people into situations where their dignity was compromised.

Carers did not always treat people with dignity and respect.

The care offered to people by Your Care put people's Human Rights at risk in regard to being treated in an inhuman or degrading way.

Is the service responsive?

Inadequate

The service was not responsive.

The care planning process in place at the service was inadequate. Care plans were incomplete, vague, inaccurate and omitted significant details in relation to a person's care.

The responsibility for assessing people's needs, completing care plans and reviews was given to staff who had been unsafely recruited and lacked the skills, knowledge and experience to appropriately complete these tasks.

People's relatives told us that they had made frequent complaints and issues were not resolved. There was no evidence to show that complaints and the information they contained had been used to improve the quality of the service provided to people.

Is the service well-led?

Inadequate

The service was not well-led.

Most people's relatives told us that the service was not well-led and that communication from the service and in particular, the registered provider was poor.

The registered provider lacked oversight and control of the service and the care that was being provided to approximately 50 people. Basic information about the service provided was not easy to obtain, systems being used were not fit for purpose.

There was no system in place for reviewing contemporaneous records relating to people's care and medication.

The poor planning of staff rosters and the deliberate 'call cramming' of people's scheduled calls made this essential service unreliable and led to people not getting the care they needed when they needed it.

The registered provider had no oversight of risks or the risk assessment process within the agency.

The registered provider did not appear to be aware of the seriousness of her responsibilities and her lack of oversight of the care provided to people.

Your 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 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 by people and their relatives telling us that they had not received scheduled calls from the service. It took place on 10, 11, 14, 15 and we contacted the relatives of people who used the service by telephone. The first day of the inspection was unannounced.

The first two days of the inspection were conducted by an adult social care inspector. Days three and four of the inspection were conducted by two adult social care inspectors.

Before the inspection we spoke with the local authority's quality assurance team who had raised concerns about the service and looked at the information that the CQC held about the agency.

During the inspection we spoke with two people who received care from the agency, the registered provider and the administrator. We spoke with the relatives of 10 people who received care from the agency.

We looked at the staff files for seven staff members. We also looked at the care files for 12 people, including care plans, assessment of needs and any other records available relating to people's care. We also looked at the computerised rostering system and obtained printouts of the rosters for upcoming days.

Inadequate

Is the service safe?

Our findings

The service was unreliable in providing necessary care and support to vulnerable adults with high care needs living in their own homes, which left them at risk of harm. At the time of our inspection we became aware that the local authority had open safeguarding referrals for 10 people in relation to missed calls from the service. This represented approximately 20% of all the people the service cared for.

Over one weekend in June 2017 a family member had written two notes to the service. We found these notes on a desk in the service's office. One note said, 'No one came Saturday morning or lunch time. Mum rang me at 12:45 to say she was hungry and hadn't had tablets.' A note dated the next day stated, 'No carers came lunch time…I hope you come in the morning because I am at work and mum is diabetic and needs to eat and have her tablets. This is upsetting her.'

We spoke with the registered provider about these notes from several weeks earlier. They had not investigated these concerns. We looked at the medication records for the time period of the notes and saw that three days of medication administration records (MAR) were blank. There were also no written records made by staff of the visits and the care offered to this person that weekend. This person was at risk of malnutrition, urinary tract infections and had a history of stroke and chronic kidney disease. Their medication was for the treatment of blood clots and stroke prevention, cholesterol, abnormal heart rhythms and blood pressure. The registered provider had little knowledge or oversight of the care received by this person during this time. This meant that this person was at significant risk of preventable harm from not receiving the care to meet their needs.

Another person was at a high risk of falling, used a catheter, had diabetes, heart problems and a history of stroke. Their family member told us that their care was unreliable. They said, "I told them, if there was a problem just to call me. I never got a phone call from them. At times mum called me to tell me that nobody had showed up. I asked them to please, don't leave my mum with no medication, no breakfast sitting in her nightdress, just call me. They wouldn't call me, they didn't take any notice." They added, "Mum was left many a time, more than 12 times."

A third person was also at high risk of falls, had diabetes, high blood pressure and chronic obstructive pulmonary disease (COPD). Their family member told us, "On at least four occasions there was a no show. During the call the carers are supposed to administer medication. Two times I was there and contacted them and they told me, 'We have not been able to get anybody'." They added, "[name] is at the end stages of COPD, uses high flow oxygen. If the carers didn't turn up she either was not put to bed and stayed up all night in a chair or went to bed without her oxygen."

A family member told us that they had such little confidence in the agency that on one occasion they were reluctant to leave when visiting their family member. They told us, "One time I thought, I can't guarantee that they'll be back so I stayed. It was a good job that I did as they didn't come back." Other family members told us of similar events.

We spoke with the registered provider about missed calls, how many there had been, how these were monitored and how they ensured the service was reliable and kept people safe. They explained to us how carers were provided with a mobile phone which logs them in and out of calls and they were alerted of any missed calls straight away by this system.

We looked at the system and found that it was not being used or monitored effectively as the registered provider had explained. The system showed that in one of the agency's seven geographical areas 185 calls were showing as missed in the past three months. The registered provider told us that these were not all missed calls. They said that they showed as missed for a variety of reasons, such as the carer not having a phone to log the call or the phone being broken. At that time of our inspection the registered provider, who carried out care calls, told us they did not have a phone on this system. This meant that the system designed to highlight missed calls was showing large amounts of unreliable information. This meant that the registered provider was not able to use this information to be assured that all visits had been completed safely. The registered provider lacked knowledge and oversight of the safety of the service and was not safeguarding vulnerable adults from neglect.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because service users were not safeguarded and protected from neglect.

People's relatives told us and we saw that the service had not ensured that people had received their medication as prescribed. This exposed people to greater risk of complications, severe illness or even death from any medical condition the medication had been prescribed for. For example, some people took medication for epilepsy, for the symptoms of Parkinson's disease, to prevent blood clotting and strokes, for high cholesterol and for various heart complaints. It was important that people received their prescribed medication, as not receiving it posed risks to their health and wellbeing.

The registered manager could not be assured that people received their medication safely because some calls were missed and they did not have oversight of which calls had been completed. Also, the documenting and recording of medication administered was inadequate and unsafe. For example, medication administration records (MAR) that we looked at in the office showed significant gaps when the forms were not being used properly and no information had been recorded with regard to what medication a person had or had not received.

On one person's MAR chart for June 2017 there were 97 blanks where it was not indicated if they had received a particular dose of medication. We looked into some of these with the registered provider. Sometimes other records indicated that the person had already received their medication before the carer arrived. On other occasions the call was recorded as completed but the MAR had been left blank. There were also times when there was no record of the call being completed or the medication being administered. On some occasions there was a different person recorded as completing the call than the person who had signed for the medication. This meant we had no confidence in the accuracy of the records. These MAR charts were in the provider's office, yet before we looked at them the registered provider had not investigated the gaps in this person's medication. This medication was very important to the person's health and safety and included two anti-epileptic medications.

For the same month another person had 59 doses of various medications that a carer had not signed to confirm had been given and had not noted any other reason for non-administration. This included medications to reduce the risk of developing blood clots, stroke and medication to treat abnormal heart rhythms such as atrial fibrillation.

For a third person we noted that a member of staff had documented as part of a spot audit on 7 August 2017 that a person had 'No MAR sheets since May. Needs addressing'. The local authority informed us that for the three months prior to May 2017 there were 52 days when there was no information on the MAR chart. During this time period the registered provider themselves had completed calls and had not addressed the inadequate records.

For a fourth person the spot audit had noted on the 7 August that there were 'no MAR sheets signed for [the] month'. The audits had been signed by the registered provider on 8 August. However, these gaps in the MAR charts and missing MAR records had not been investigated by the registered provider.

At the start of the inspection the registered provider told us that the service had "never missed medication". However, the system and records in place meant that they were not in a position to give such assurances. The records were inadequate and there was a pattern of them not been completed by staff members. This meant that the registered provider could not be assured that people were receiving their medication safely and as prescribed. This left people at risk of avoidable harm.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the registered provider had not ensured the proper and safe management of medicines.

The methods used for recruiting new staff were unsafe. We looked at the files for seven staff members and not one of them had been safely recruited. Employers providing a regulated activity are obligated to check that persons employed are of 'good character'. They are obligated to check applicant's proof of identity and obtain evidence of conduct in previous employment relating to health and social care along with the reason why this employment ended. This is usually obtained through written references. Employers are also obligated to obtain evidence of qualifications and a full employment history of the person.

The registered provider had failed to complete their obligations for any of the seven staff members we looked at. Not one person had a written reference. Three people had only a brief and incomplete note from a phone conversation about a candidate with a previous employer. Only two people had provided their work history and only one person had any reference to identification on their file. We discussed this with the registered provider who was unaware of their obligations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They told us that "obtaining written references was difficult".

During our inspection we also became aware that three recently recruited staff had completed over 380 calls to support vulnerable people in their homes without the registered provider completing or applying for a disclosure and barring service (DBS) check. DBS checks assist employers to make safer decisions about the recruitment of staff. They consist of a check on criminal records and to see if people have been placed on a list barring them from working with vulnerable adults. This had not been completed so the registered provider could not be fully assured that these three staff that had been employed were suitable to work with vulnerable people.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the registered provider had not taken steps to ensure that people employed were fit and proper persons for the role.

There was no evidence that any staff had received training in safeguarding vulnerable adults. This is essential training as it equips staff members with the knowledge to be aware of and react appropriately to anything that may indicate a vulnerable adult is at risk of abuse. It also makes staff aware of their

responsibilities to report events that place a vulnerable adult at risk both inside and outside the organisation. This is recognised as essential mandatory training and is part of the minimum standards of induction training as set out by the government appointed body 'Skills for Care'.

After repeated requests the registered provider was not able to show any records relating to safeguarding training for staff members. We did speak with one member of staff who was involved in answering telephone calls and completing care plans and assessments of people's needs in their homes. This person was often the first point of contact for people cared for, their friends and relatives and any health professionals. They confirmed to us that they had not received training in safeguarding vulnerable adults and when asked was unable to show us the agency's policy on safeguarding.

The registered provider had not taken steps to ensure that staff members were equipped with the knowledge and skills to ensure that vulnerable adults were protected from abuse. This meant that any potential abuse may be missed and not reported appropriately.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because staff members were not equipped with the knowledge and skills to ensure that vulnerable adults were protected from abuse.

The system in place for assessing risks to people was inadequate. The service did not have an effective risk screening process in place to identify and mitigate the risks associated with the people it supported. In many people's care files we looked at there were clear risks present that had not been assessed at all. There was no evidence that people or, if appropriate, their relatives had been involved in decisions with regard to how risks were managed and there was no evidence that referrals had been made to or advice sought from professionals on how to reduce risks. The administrator of the organisation was not able to show us any policies in regard to how the service planned to manage risks. We became aware of many risks only after confirming people's assessed needs with the local authority.

This exposed people to increased risk of harm. For example, one person was at risk of malnutrition. Their care plan stated '[Name] has a little appetite and is forgetting to eat.' And 'struggles to cook for herself which could result in decline in health'. However, there was no risk assessment for malnutrition in their care plan, nor was there any guidance for care staff on how to mitigate these risks.

Another person's care plan notes that they were at risk of choking and their food needs to be cut up for them. There was no risk assessment in place for this, nor was there any supporting information or guidance for staff from relevant health professionals. This placed the person at increased risk of developing aspiration pneumonia or choking and death.

A third person had epilepsy. There was no mention of this at all in their care plan and there was no risk assessment in place for any risks associated with this care need.

The process for assessing people's needs and assessing risks had not highlighted or addressed significant risks in people's care. There were many examples of serious omissions that meant that staff members did not have access to essential information needed to care for people safely. They also did not have information to help them become aware of problems and guidance if situations arose. This meant that people were at increased risk of receiving unsafe care from staff that were not aware of the risks present in people's care. This placed people at unnecessary and increased risk of avoidable harm.

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

2014. This is because the risks to the health and safety of people using the service had not been assessed.

The service did not have sufficient staff employed to care for people's needs safely. The provider was heavily reliant on support from outside agencies to provide staff. One family member described the service they received as, "A right mismatch of carers". Another told us, "They were always sending different people."

The rosters demonstrated that staff were rostered to attend up to four and five calls at the same time each day. This meant that there was never any possibility that all people using the service would receive their support at the required times. There was also significant evidence that demonstrated that people did not receive their care for the required call time. We were given evidence that one staff member left their car running whilst they ran inside the person's house and did a quick check instead of the designated care visit.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service did not have adequate staffing to meet the needs of the people safely.

Inadequate

Is the service effective?

Our findings

In the seven staff files we looked at there was no reference to any training being provided by the agency. We spoke with one staff member who told us that they had received no training at all apart from being shown the computerised system. After repeated requests the registered provider was not able to show us any records to demonstrate that they provided their staff members with the training that is necessary for them to be effective in their role. This included essential core training that all care staff are expected to receive near the start of their role as outlined by Skills for Care; the government appointed body for setting standards of training in the care sector. Examples of necessary training include understanding your role, duty of care, working in a person centred way, communication, safeguarding vulnerable adults, fluids and nutrition, privacy and dignity, health and safety and infection prevention and control.

We also saw that there was no evidence that new staff received any induction or shadow period to introduce them to the people being cared for and ensure they were suitable for the role identified. The lack of induction and training meant that the registered provider could not be assured that staff members were able to effectively carry out the duties they had been employed to perform.

The lack of effective induction had an impact on the experience of people receiving care. At times they received care from staff members that they were unfamiliar with. Family members told us that they had felt uneasy with this situation. For example one person's relative told us, "There was no introduction and no assessment. They just turned up and said they had come to give my mother her medication. I told them I don't know who you are or where you are from." Another relative told us, "A new carer started, we knew her first name but not surname. She had no uniform and no ID badge." A third said, "There was no consistency since they started last year. They were never consistent. It upsets my mum as she says that she does not know these people."

There was very little evidence of ongoing support in the seven staff files we looked at. One staff member's file contained the notes from two supervision meetings. These were meetings when concerns about areas of their performance had been addressed by the registered provider. Another staff member had an appraisal where they also had issues with regard to their performance raised with them. This was the only evidence of any ongoing support of the seven care staff. There was no structured method used by the provider of assessing the performance and suitability of staff in performing their role of supporting vulnerable adults.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because staff had not received appropriate training, support and professional development to enable them to carry out their duties effectively.

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.

People can only be deprived of their liberty so that they can 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.
There was no evidence that any staff had been provided with any awareness training with regard to the MCA. This included staff who were completing people's assessment of needs, care plans and reviews of care.
Some people's care plans made reference to people's capacity to understand their care needs. For example on person's care plan stated that the person, 'Understands the need for care'. However their care plan and a 'consent to care and treatment form' had not been signed by the person in the designated place. We looked at this consent form for seven people and none of them had been signed by a person or their advocate. However they had all been signed and dated as 'witnessed' by a Your Care staff member. We looked at five care plan reviews, three were signed and dated by staff but were otherwise blank and all had not been signed by the person cared for. Obtaining people's consent to the care provided looked like an incomplete paperwork exercise.
We could not see any evidence of when appropriate consideration had been given to obtaining people's consent to their care or respecting their rights to choice and making decisions.
This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the service gave no regard to obtaining people's consent to their care.

The service did not adequately support people to eat and drink safely. Many care visits were specifically assessed to ensure that people ate and drank adequate amounts. Due to the high volume of missed calls, the service was failing to support people to have appropriate food and drink. This placed people at high risk from harm. Some of the people using the service had diabetes where food is required to be carefully managed. Other people had dementia and would forget to eat unless prompted.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service failed to meet people's needs in relation to nutrition and hydration.

Inadequate

Is the service caring?

Our findings

People's relatives told us that individual staff members had a caring approach. One person's family member told us, "There was one carer I could rely on." Another said of some carers, "They seem on the ball and quite good." A third told us, "They are alright; we got on really well with a couple of the carers. It was a good service at times. Although a couple of times they didn't call at all. I have to look after mum by myself." A fourth said, "Care from staff was fine, individual staff members were okay. We got on well with them. The issues were missed calls, must be 30 plus calls missed since November 2016."

Many people's relatives reported that a lack of experienced and trained staff, the approach of some staff members and systematic lack of attention to the care needs of vulnerable adults by the management meant that the service was not caring towards their family members.

The unreliability of the service and its poor communication meant that people were sometimes put into situations where their dignity was compromised. For example, one person's family member told us, "One time [name] called me and said nobody had called. It was 10:30 pm and the carer was due at 8pm. I went around at 11:30 and had to get my aunt undressed and ready for bed. I have never had to do this before. It was embarrassing for both of us and undignified that I had to do this. I complained and was told that the carer had decided not to turn up." The person's relative added that another time because of a missed call, "I called to find [name] sat in her own urine. You wouldn't treat animals like this."

Another person told us, "A man came around to wash and dress mum. She didn't know him at all. She refused. This was very upsetting for my mum, it upset her dignity." A third person's family member told us of a time when the person's granddaughter had to give them a shower because a carer had not arrived. The local authority told us of a report about a fourth person from a social worker who visited a person cared for by Your Care and found them 'looking for food as the carer hadn't left any'. This was because the carer was running three hours late and the person or their family members had not been informed.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the lack of reliability and poor communication from Your Care had forced people to seek basic care in a manner that was not dignified.

At times carers had not always treated people with dignity and respect. One family member told us that they went upstairs and found that, "Mum was left naked on the landing and the carer was on the phone to the office." They went on to tell us how upsetting this was for them to see their relative left in this way. Telling us, "The amount of times I have come home from my mum's crying. Mum doesn't understand and this has all caused her extra confusion".

Another person's family member told us of a time when a carer turned up over two hours late for their relative's call. They told us, "They were two hours late and didn't acknowledge that they were late or apologise. When I pointed this out the carer said [in the presence of the person], 'You don't know what day I'm having or what it's like being a carer and what I have to put up with'. I was shocked, there was no

professionalism."

People relatives told us that they and their family members were not communicated with and felt ignored by the agency. They told us of times when they were not treated with respect by the staff and manager of the agency. For example, we were told that often the carers were late and there was no communication about this or information was misleading. This left people and their family members in the dark which caused unnecessary increased anxiety. For example, one person's family member said, "Very often they are late; two and a half hours is nothing unusual." Another said, "One time carers didn't show for a 9pm call. I went to care for [name] myself and text the agency to say I had called and they had been cared for. I went to bed and the carer rang me after midnight to say she was not able to get in." A third family member told us, "One time they lied to me and told me somebody was there and they were not there".

One person's family member told us, "They made me feel angry and vulnerable. I can't imagine how their clients felt. I understand at times people can be late, but they don't contact and ring. Nobody ever did." Another person's family member told us that because of missed calls, "Mum found the whole thing confusing with her dementia and this upset her. I feel it left my mum vulnerable."

The family member who referred to there being over 30 missed calls since November 2016 told us of the impact on their relative saying, "She is a 93 year-old lady who is slightly deaf and her mobility is not brilliant. She can't prepare food and can't make hot drinks. Not knowing what is happening causes a lot of confusion".

This is also a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because people had not always been treated with dignity and respect.

The care offered to people by Your Care put their Human Rights at risk in regard to being treated in an inhuman or degrading way.

Inadequate

Is the service responsive?

Our findings

People's family members told us that the care planning process in place at the service was inadequate. We were told of many examples when the staff members arriving to provide care did not know the needs of the people they were caring for. For example, one person's relative told us, "The care plan was very vague. It doesn't give instructions for staff. In the end I had to write my own instructions for carers." Another said, "Mum used to say that they never do what we want them to. We sat down with them and wrote down mum's likes and dislikes and dos and don'ts. But they never took any notice of it." A third family member told us, "They didn't know my mum's needs. They didn't know my mum. One carer asked me, 'What exactly is wrong with your mum?' There was no care plan or paperwork in the house, so I had no clue if anybody had turned up for calls. I was told that somebody had taken it back to the office." A fourth family member said, "I had to check because they had forgotten to give medication many times. I said to a carer once, 'you should have given medication last night'. She said, 'I didn't know I had to'."

We saw care plans that were only half completed and some family members told us that the service started with no care plans in place. One family member told us, "There was no care plan at the start, until a social worker got involved. They didn't record their visits in the book, so there was no information available to me. The manager told me, 'sometimes people don't write in the book'".
Another family member said about the care planning process, "I'm having to ask questions all the time and write messages for carers in the book. From day one I'd have expected a care plan and risk assessment. There was nothing in the house, I had to repeatedly chase for these. I arranged a meeting and got a care plan. But the care plan did not address [name's] needs. The care plan said [name] could walk unaided and they can't, it said they were continent and they are not."

During our inspection we saw many examples of care plans that were incomplete, inaccurate and omitted significant details in relation to a person's care. For example, one person required care from two people to assist with safe moving and handling. Their family member told us, "There was supposed to be two carers at lunchtime but a lot of times they sent one. I had to help out or they do it by themselves." We looked at the care plan for this person and it made no reference to two carers being required to help the person move safely and didn't give any guidance on how a person was to be moved safely. The person's care had not been safely planned according to their needs. This meant the person was put at increased risk of having an accident and being injured whilst moving.

Some guidance for staff was too vague. It meant that care staff did not have the necessary information to be confident in providing the correct and safe care for people. One person's care plan stated 'Cream to be applied to body'. It did not state what the cream was, the reason for its application or where on the person's body it should be applied.

People's care plans did not outline what medication a person was taking or the reasons why they were taking it. If medication was mentioned it was only briefly to note that staff are to support a person to take it. One family member said that a staff member told them, "They were not doing [name's] tablets because they didn't know what tablets to give her." This meant that staff had inadequate information to be able to

support this person safely.

Another person had stage 3 chronic kidney disease (CKD) that placed them at risk of urinary tract infections (UTIs). The local authority stated that part of their care plan should be for "Carers to dip urine regularly to check for UTI." There was no reference to this care need in this person's care plan and the relevant section of the plan was blank. We saw no evidence to suggest that care staff were aware of this need, had the appropriate equipment to meet this need or the necessary training and guidance to do so. An undetected and untreated UTI placed this person at risk of kidney damage through spread of the infection.

A fifth example involved a person supported by the service who had cerebral palsy and epilepsy. There is no mention of this in his care plan. There is no reference to the medication he needs to manage his epilepsy. We did not see any evidence to show that care staff had the appropriate information or knowledge to ensure that they are safe in meeting this person's care needs.

Most people's care plans that we looked at did not identify the times and lengths of the visits that people required receiving their care. This meant that there was an increased risk that people did not receive care at the times they needed it and for the agreed amount of time. One family member told us that they were in dispute with the service regarding what length of call had been commissioned by the local authority and that this had not been outlined in the care plan. One family member told us, "The manager said we were due half an hour in the morning and it was one hour, even after we checked with social services they carried on doing less than half an hour."

We saw that some people's assessment of needs, care plans and care plan reviews had been written by two particular staff members. The registered provider had no documented evidence of the work history or experience, no written references and no evidence of any induction, training or ongoing supervision for these staff members. The registered provider did not have any evidence to ensure that these staff members were suitable for this responsible role, which included compiling and reviewing the care plans and needs assessments for vulnerable adults some of whom had complex support needs.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because people's care planning was inadequate and did not equip staff to be able to meet people's needs.

People's relatives told us that they had made frequent complaints and issues were not resolved, They said that communication when raising issues was poor and they did not feel listened to. One family member told us, "You wouldn't believe the times I complained to them. There were excuses left, right and centre." Another family member said, "When calling the office, we just get an answer machine and nobody rings you back. It's so hard to get problems sorted out. We always get told that they are short staffed and people are off sick."

When people and their family members raised a complaint we were told that things did not improve. One family member stated that, "There was no real response to complaints. They said they would ring me back and they didn't. Or tell me they would get the manager to call me, they never did." A fourth told us that when they raised a complaint, "They argued between themselves, one person said they had let the carer know, the carer said nobody had told them. They never let us know anything. Their communication was absolutely diabolical, the worst ever."

The registered provider was not able to show us a record of complaints received and their responses. There was no evidence that complaints and the information they contained had been used to improve the quality of the service provided to people.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the registered provider had not taken necessary and proportionate action to resolve complaints.

Inadequate

Is the service well-led?

Our findings

When we asked one person about the service they said, "They are rubbish." Most people's relatives told us that the service was not well-led and that communication from the service and, in particular, the registered provider was poor. Feedback included the following comments, "The organisation let me down. I didn't feel I could talk to anybody when things went wrong"; "The service put a strain on the family as we could never rely on them and couldn't get through on the phone", "If you ever hit a problem you can't get hold of them", "I could never get hold of the manager. When I did it just went over their head, they were not bothered", "I kept saying to the manager, please improve. We can't be checking that you are coming every day. There are loads of missed visits" and, "The service is supposed to take the stress away from me. I ended up being around there more than beforehand…I was more stressed because of the poor care provided…I was complaining all the time".

The registered provider told us that their priority was always the "patient" and their aim was to be flexible with people. They said that nearly all the staff were over thirty years of age and therefore had life experience and were very caring. They told us that they were very responsive to safeguarding. However we saw evidence that clearly contradicted this statement.

During our inspection we saw that the registered provider lacked oversight and control of the service and the care that was being provided to the people it supported. Basic systems being used were not fit for purpose. For example, the registered provider was unable to produce for us from their system an accurate list of the people who they were currently providing care for. They were also unable to produce from their system an accurate list of current staff members. They had information on their computerised management system that was out of date on the system that was currently being used to plan people's care. We also saw over the four days of visiting the office that the registered provider had little protected time to oversee the service provided as they were on the roster completing calls due to being short staffed.

There was no system in place for reviewing contemporaneous records relating to people's care. We asked to look at people's medication and daily care records and we were told that they did not have a filing system for completed MAR charts and daily support records. The registered provider told us that months of these records were still in people's homes and that these had not been reviewed by themselves or a senior member of staff. We looked at a sample of records that were on a desk in the office and saw that medication records were incomplete and that there were gaps in the contemporaneous records of the care provided to people. No records we looked at were complete. The registered provider told us that carers made notes on their phones which updated onto the computerised system. We looked at these electronic records for some dates and saw that this was not always the case.

People's family members told us that there were often blank sections in the book, which meant either no records of people's care had been made, or nobody had been to care for the person. One person's family member told us, "At times there were no records to show that the carer had been. We thought the call may have been missed. The manager told us that the carer had been because the electronic tag showed the carer was present, but the carer 'Did not have a pen' to record their visit."

The registered provider had not ensured that accurate and up-to-date records had been completed and maintained of the care provided to people. This meant that they could not be assured of the quality of care provided to people.

The registered provider completed the rosters for staff. We saw that it was common practice to double-book carers by 'call cramming' the visit times together. There was also a lack of appropriate forward planning, as during our inspection we saw that not all required calls for the next two days had been assigned to a member of staff. We looked at the call roster for one staff member for a two-day period. Over the two days they had been scheduled to complete 37 calls. This was impossible to complete as this single carer was scheduled to be in more than one place at the same time at four separate occasions during the day. At 5pm on both days the carer was scheduled to be visiting five different people, in five different places. A sixth person was also scheduled to be seen at 5:30pm. The planned roster for this period meant that it was impossible for people to receive their care when it was needed and planned for. It was inevitable and obvious to the registered provider, as the person creating the rosters, that the carer was going to be significantly late for people's tea time calls and that some people would be forced to wait for their care for hours, leaving some people hungry, thirsty and without the support they needed to use the toilet.

Many people's relatives told us that people's call time was cut short and staff were often late and stressed. One person's relative told us, "The carer showed me she had to be with three people at 9pm. The carer said, 'I've no idea how that works'." Another told us, "Carers are under a lot of pressure to get in and out." A third said, "Carers were coming in for five minutes and saying they had been there for half an hour." One person's relative told us of a time when the carer was stressed because she was walking between calls and was running late. The relative told us that, "The carer had to get some distance and was over an hour late. She was crying and frustrated so I gave her a lift in my car to help her not be too late for her next call. The carer told me at times they didn't get any time between calls. She showed me the rota and they didn't always have travel time in-between calls." The person's relative told us, "I blame the company for putting the girls in this situation."

The poor planning of staff rosters and the deliberate 'call cramming' of people's scheduled calls made this essential service unreliable and led to people not getting their necessary care at the allocated time. This also meant that people were put at increased risk of not receiving necessary care in a safe manner.

The registered provider had no oversight of risks or the risk assessment process within the agency. The process for assessing people's needs and assessing risks was inadequate, as it had repeatedly failed to highlight or address significant risks in people's care.

The registered provider did not appear to be aware of the seriousness of her lack of oversight and the significant risks this posed to the people relying upon the service for their care. It is by chance that this combination of a lack of oversight of the service, inadequate records, inadequate risk assessing, inadequate rostering, unsafely recruited care staff, missed calls and missed medication had not led to a vulnerable adult suffering significant harm.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the registered provider had not maintained systems or processes that allowed them to assess, monitor or improve the quality and safety of the care being provided. The registered provider had also not maintained systems or processes that allowed them to assess, monitor and mitigate risks relating to the health, safety and welfare of service users and they had not maintained complete records in relation to people's care.

The registered provider told us that they conduct monthly 'spot audits of service delivery', telling us they, "Go out every four to six weeks." We asked for a sample and were shown five completed audits with dates in August 2017. These documented reasonable levels of satisfaction, however there were themes of calls being late and MAR sheets and daily care records not being available or completed correctly. We asked to see a sample of earlier audits but we were told that none were completed in July. We asked for samples from earlier than July and were told that the five in August were the only ones that have been completed as the process had only recently started. Prior to August 2017 there was no quality control or assessment system in place for an organisation supporting approximately 50 people.

At the inspection we discussed with the registered provider their obligation to notify the Care Quality Commission of specific events. We looked at the legislation together which showed what events were notifiable and how the registered provider should notify the Commission. The registered provider told us that no notifiable events had happened.

During our inspection we became aware that the registered provider had failed to notify the Care Quality Commission of events that she had a statutory obligation to report. These included occasions when they were aware that allegations of abuse in the form of neglect had been made and a notification that was due regarding the death of a service user.

This is a breach of Regulation 18 of Care Quality Commission (Registration) regulations 2009. Failure to notify the Commission of notifiable incidents.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Failure to notify the Commission of notifiable incidents.

The enforcement action we took:

Urgent cancellation

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care This is because people's care planning was inadequate and did not equip staff to be able to meet people's needs.

The enforcement action we took:

Urgent cancellation

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect This is because the lack of reliability and poor communication from Your Care had forced people to seek basic care in a manner that was not dignified. Also people had not always been treated with dignity and respect.

The enforcement action we took:

Urgent cancellation

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent This is because the service gave no regard to obtaining people's consent to their care.

The enforcement action we took:

Urgent cancellation

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment This is because the risks to the health and safety of people using the service had not been assessed. Also the registered provider had not ensured the proper and safe management of medicines; and the service failed to meet people's needs in relation to nutrition and hydration.

The enforcement action we took:

Urgent cancellation

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment This is because service users were not safeguarded and protected from neglect. Also staff members were not equipped with the knowledge and skills to ensure that vulnerable adults were protected from abuse.

The enforcement action we took:

Urgent cancellation

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints This is because the registered provider had not taken necessary and proportionate action to resolve complaints.

The enforcement action we took:

Urgent cancellation

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance This is because the registered provider had not maintained systems or processes that allowed them to assess, monitor or improve the quality and safety of the care being provided. The registered provider had also not maintained systems or processes that allowed them to assess, monitor and mitigate risks relating to the health, safety and welfare of service users and they had

not maintained complete records in relation to people's care.

The enforcement action we took:

Urgent cancellation

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed This is because the registered provider had not taken steps to ensure that people employed were fit and proper persons for the role.

The enforcement action we took:

Urgent cancellation

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing This is because the service did not have adequate staffing to meet the needs of the people safely and staff had not received appropriate training, support and professional development to enable them to carry out their duties effectively.

The enforcement action we took:

Urgent cancellation