Community Care North East

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Inspection report

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Date of inspection visit:
08 November 2016
09 November 2016
15 November 2016
16 November 2016
17 November 2016
28 November 2016
16 January 2017
17 January 2017
19 January 2017
20 January 2017

Date of publication:
17 March 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 8, 9, 15, 16, 17, 28 November 2016 and 16, 17, 19 and 20 January 2017. We announced this inspection because we wanted to make sure people who used the service in their own homes and staff who were office based were available to talk with us.

At our last inspection of Community Care North East in April 2016 we reported that the registered providers were in breach of the following:-

Regulation 9: Person Centred Care

Regulation 12: Safe care and treatment

Regulation 13: Safeguarding service users from abuse

Regulation 17: Good governance

Regulation 18: Staffing

Regulation 18 (HSCA Registration regulations): Notifications

Regulation 19: Fit and proper persons employed

We took enforcement action (Warning Notices) for Breaches of Regulations 12, 17 and 19.

At this inspection we found there were further and continuing breaches of Regulations.

Community Care North East is registered with the Care Quality Commission to provide personal care to people who wish to remain independent in their own homes. The agency covers areas within County Durham and Gateshead.

62 people were using this service when we visited and there were 30 staff.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

People's care plans were not person centred, detailed or written in a way that accurately described their individual care, treatment and support needs. Care planning was not consistent and did not ensure that all

staff were clear about how people were to be supported and their personal objectives met. Some peoples' needs or complex conditions were not mentioned in care plans. Care plans were not regularly evaluated, reviewed and updated.

People were at risk of receiving inappropriate care and that reasonably practicable steps to reduce any such risks had not been taken.

There had been no registered manager for this service since March 2016. The provider had appointed an acting manager who could act for the provider during inspection three weeks prior to this inspection taking place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who used the service. We saw risk assessments which were required had not been carried out and others were not updated if new situations or needs arose.

We found the provider was not following safe recruitment procedures or applying the organisations own recruitment policy safely. The provider had not undertaken competent background checks for some staff before they started working with vulnerable people.

We found that the administration of medicines did not follow best practice guidance. The provider could not demonstrate that people were receiving their medication as prescribed. Administration procedures and systems to ensure the proper and safe management of medicines were not in place.

The provider's arrangements to assess monitor and improve the safety of people supported by the provider was ineffective. People using the service had sustained accidental injuries whilst being supported by CCNE staff without these being known by senior staff or the acting manager. The provider's arrangements to assess monitor and improve the safety of people supported by the provider was ineffective.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We found the acting manager had an understanding about how the service was required to uphold the principles of the MCA, and when people needed additional support to ensure decisions about their best interests were robust and their legal rights protected.

Staff had not received appropriate specialised training to meet their needs of the people they supported. The providers' training programme was not robust and did not support staff to gain the skills and knowledge they needed to meet the needs of people who used the service. This meant that persons providing care or treatment did not have the qualifications, competence, skills and experience to do so safely and measures to mitigate the risk to people using services were not in place.

The provider advertised on their website that the service was CCNE was a 'City & Guilds Approved Centre of

Specialist Care Training.' The registered provider subsequently agreed that CCNE was not approved by City and Guilds and that this should have been removed from the website as it was misleading staff and the public.

Statutory notifications about important issues had not been made and records that the provider was required by law to keep, were found not to be in place.

People were not protected from the risk of abuse. The provider had failed to respond appropriately to incidents where abuse was suspected involving staff at the service.

At the last inspection in April 2016 we found the provider had moved the registered location from the address at Belgrave House without ensuring that registration with CQC at the new address had taken place. At this inspection we found the provider had again not met the requirements of their registration and had failed to apply to CQC to notify of the change of address.

The registered provider was offering services to support children without having submitted legal Notification to CQC that the providers' 'Statement of Purpose' now included this service user group. The acting manager was also unable to demonstrate how the provider had ensured that legislation in relation to children such as The Children Act 1989 (and subsequent related legislation) were implemented.

Some people using the service did not have a signed agreement to indicate they had consented to the support offered by the provider.

We found that some people had not received the amount of staff time they had paid for and the acting manager was unaware of the shortfall. This showed that systems to monitor the performance of the service were ineffective and placed service users at risk of not receiving a service they needed, agreed and paid for.

The provider did not have effective systems in place for monitoring the quality of the service or using information to critically review the service. Feedback from relevant persons so the provider could continually evaluate and improve services was not in place.

The service had a complaints policy which provided people who used the service and their representatives with information about how to raise any concerns and how they would be managed.

During our inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Care Quality Commission (Registration) Regulations 2009. These are listed throughout the report. You can see what action we told the registered provider to take at the back of the full version of the report.

Details of any enforcement action taken by CQC will be only be detailed once appeals and representation processes have been completed.

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.

Procedures to safeguard people using services from abuse were not robust.

Staff recruitment procedures did not protect vulnerable people using the service from the potential risk of harm from unsuitable staff.

Systems which should have been in place to manage risks were not effective or in some cases not in place at all.

Arrangements for the administration of medication were not robust

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not receive suitable training and development to ensure they were sufficiently knowledgeable and competent to meet the needs of people they supported.

Communication, supervision and support from the acting manager and senior staff did not resolve identified issues.

Best practice approaches to providing safe care were not in place.

Is the service caring?

Requires Improvement

The service was not always caring.

Some staff had not reported or resolved incidents involving the care or wellbeing of people using the service.

People were not always supported by staff to remain independent.

Some people using the service reported positive relationships with their carers.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Arrangements for the assessment, planning and review of peoples' needs were not consistently in place.

Care plan records were not person centred or demonstrated the use of individual approaches.

Is the service well-led?

Inadequate

The service was not well led.

The management systems which should have ensured the service was well-led were ineffective.
There was not a registered manager in place.

The provider did not have had effective systems in place to assess, monitor and drive the quality of the service.

Records that were required by law to be in place were not always kept.

Important statutory notifications which were legally required to be made had not been done so.

Community Care North East

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 registered 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.

Three adult social care inspectors completed this announced inspection of Community Care North East on 8, 9, 15, 16, 17 and 28 November 2016 and 16, 17, 19 and 20 January 2017. We announced this inspection because we wanted to visit people who used the service in their own homes and staff who were office based were available to talk with us. We carried out further visits to the providers' offices and people's homes in January 2017 to verify and ensure urgent actions which we brought to the attention of the provider, had been acted upon.

Before the inspection we reviewed all the information we held about the service. We reviewed any notifications that we had received from the service and information from people who had contacted us about the service since the last inspection. For example, people who wished to compliment or had information that they thought would be useful to us. A notification is information about important events which the service is required to send to the Commission by law.

Before the inspection we reviewed information from the local safeguarding teams, local authority and health services commissioners in which the provider operated. Prior to the inspection we also contacted the local Healthwatch. Healthwatch is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, concerns and compliments through their engagement work. Information given by these public bodies were used to inform the inspection process.

During the inspection we spoke with seven people who used the service and their relatives in their homes. We spoke with three staff and the acting manager who was in charge of the service at the time of the inspection.

We also spent time looking at records, which included twelve people's care records, and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

At our last inspection in April 2016 we found the registered provider was in breach of Regulations 12, 13 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us they felt safe because, "The staff come to my house every day, I rely on them to make sure I'm alright and look forward to their visits and company." One relative told us, "Both of us are so much better now we have the help of these (staff) and having direct control over the budget is makes things a lot more straightforward."

At our inspection in April 2016 we found that there were gaps in employment records which showed staff member's previous work history had not been adequately checked to ensure they were suitable to work with vulnerable people. We looked again at the recruitment records of staff who had been employed to work for the care agency since that date. The staff recruitment process included completion of an application form, an interview, two references, a Disclosure and Barring Service (DBS) check and previous work history to identify any gaps in employment. (The DBS enables employers to check if applicants have a criminal background.) However we found that in some cases previous work history dates were not always provided. This meant it was difficult for the provider to identify and clarify people's employment history.

The acting manager confirmed that there was now a risk assessment carried out where the Disclosure and Barring Service (DBS) check indicated prospective staff had a record of previous criminal activity. We looked at how this had been used for one staff member's employment record and found that a check had been carried out which indicated they had previously been convicted of a criminal offence. Whilst the date of the offence was subsequently proved to be an error, they had actually been employed for a period of five weeks before written confirmation from DBS confirmed the offence date was an error. However, we saw the 'CRB Risk assessment form' completed at the time of employment, had not included the offence. This showed that the offence was not taken into consideration in determining if they were suitable to work with vulnerable people at the time when it had not been proven to have a date error. This showed that the provider's recruitment procedures had not be operated effectively to demonstrate they employed people of good character.

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

When we visited the providers' offices we looked at a sample of five people's medication administration records (MAR) in which CCNE staff were intended to record when they had administered medication. We saw that some people had been prescribed multiple medications which required to be administered at a variety of times each day. However when we looked at the MAR for one person we found that their medications were described as 'Dosett box' and on three separate weekly MAR the actual medications were not listed. This meant that the actual medicines administered by the provider could not be verified and the person was at risk due to potential medication errors. We found three people who required staff from the service to administer medication, had unexplained gaps in their MAR. This included medicines for serious conditions

such as heart failure and vein conditions. This meant that people using the service may not have been administered with their prescribed treatments they required placing them at risk of medical complications. We drew this to the attention of the acting manager for their immediate action.

Some people using the service required staff to remind and assist them to take medicines which were required injections such as treatments for Diabetes. We looked at people's daily notes which had been completed by staff and found that on occasion, medication was not administered as had been required putting people at serious risk. We drew this to the attention of the acting manager and made a Safeguarding Adults Alert to the Local Authority to ensure people using the service were protected from further risk of harm.

Some people who were supported by the service required staff to administer topical medicines (creams applied to the skin). We looked at the directions that had been given to staff and found some were not clear. For example one person was to have their topical medicines applied with the instruction 'legs' another was to have theirs applied to 'all sores - as required' and also another treatment to be given 'when required.' We did not find body maps which would explain to staff where and when treatments were to be given and guide their practice. This meant the provider could not demonstrate that people were receiving their medication as prescribed. We drew this to the attention of the acting manager for their immediate action.
We found people were not protected from the risks associated with their care because the provider had not assessed the risk to people and put in place actions to mitigate those risks.

We met with one person who told us that they suffered from epilepsy and staff from CCNE were to support them. Care records stated that CCNE staff would ensure they were 'prompted and supervised' to take medication. However there was no risk assessment which had been carried out by CCNE to show that the provider had considered the risk of this person's epilepsy. There were no details of emergency measures CCNE staff should take should this person experience an epilepsy episode. The acting manager agreed that the care documents did not give detail of the steps staff should take to support this person and steps to monitor and mitigate risks were not in place.

We found one person who had a 'moving and handling risk assessment' in which it gave staff directions if they were to have an epilepsy incident. The stated, "The carers are to just direct (their) fall to the floor and allow (them) to see it through. The carers are not to hold on to her whilst (name) fits." There was no indication as to how staff were to ensure this persons safety including the availability of other members of the family who could assist / take charge, methods to prevent injury and hasten recovery or the length of time before additional medical attention should be considered.

The registered provider was also supporting this person to bathe. However there was no risk assessment which had been carried out by CCNE to show that the provider had considered the risk of this person's epilepsy or the type of equipment to be used to aid their bathing safely and protect them from drowning. There were no details of emergency measures CCNE staff should take should this person experience an epilepsy episode whilst bathing. The acting manager agreed that the care documents did not give detail of the steps staff should take to support this person and steps to monitor and mitigate risks were not in place.

One person who used the service had been assessed by the Speech and Language Therapy team (SALT) as being at 'Risk of Choking' when being supported to eat by CCNE staff. However there was no risk assessment which had been carried out by CCNE to show that the provider had considered the risk of them choking. The provider had not constructed a care plan which included the measures staff should take to reduce the risk of the person choking as advised by the SALT team. There were no care plans in place which described the actions staff should take should the person begin to choke. The acting manager agreed that this person's

care plan did not give these details. This meant that arrangements to ensure the proper and safe care of people using the service were not in place, putting them at risk of receiving inappropriate care and that reasonably practicable steps to mitigate any such risks had not been taken.

The provider had a policy in place to promote infection control by staff. We saw staff had access to appropriate personal protective equipment (PPE) such as disposable gloves and aprons. However we found that where people had suffered from serious infection and had an increased likelihood of a re-occurrence, then this risk was not considered as part of their care plans. This showed the provider had not considered measures to mitigate harm where staff were at an increased infection control risk and did not have plans in place to take suitable and timely action to get people access to treatment if this was required.

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

We saw staff had been provided with safeguarding training. Prior to this inspection one of the local councils where the provider operates informed us that a safeguarding alert had been made to them about an incident involving the provider's staff. We asked the acting manager to provide evidence of the actions taken in response to a safeguarding alert involving a member of staff who was, at the time, employed by CCNE. The acting manager could not give a detailed account or evidence of the actions that were taken as a result of this incident. This meant that the provider was unable to demonstrate that safeguarding procedures, intended to ensure the safety of people using services had not been followed.

This is a Breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the records of accidents and incidents involving staff and people using the service. The provider's Health and Safety Policy and Procedure dated August 2015 stated, "All incidents no matter how minor are to be reported in the company's accident book" and "Significant accidents will be investigated to ensure appropriate preventative measures are implemented." We examined a sample of daily records completed by staff when visiting people in their homes. We found reports in service user's records which had been completed by staff that an incident had occurred where one person had been injured by hot food prepared by CCNE staff. The acting manager told us that they were not aware that the incident had taken place, that the staff had not informed senior staff and the record of the incident had not been reviewed by senior staff. This showed that the provider's arrangements to assess monitor and improve the safety of people supported by the provider was ineffective.

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

Requires Improvement

Is the service effective?

Our findings

At our last inspection in April 2016 we found the registered provider was in breach of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Whilst we found the registered provider had made some improvements at this inspection we found continued Breaches of Regulations which affected the safety of people using the service.

During our last inspection in April 2016 we found the provider could not demonstrate that staff had undertaken routine training which enabled them to carry out their duties.

We asked people we visited if they felt staff had the right training and skills to meet their needs. One relative said "They're very good at care but a surprising number of (staff) just can't cook." Another said, "They were very receptive to the training to start with which helped me to be more confident in their skills."

At this inspection we looked at records to see if all staff had achieved training which was relevant to their roles and enabled them to meet the needs of the people who used the service. We found staff were supporting people to eat who had been assessed by their social worker as being 'at 'risk of choking': staff were supporting people who were at risk of having an epilepsy emergency. The acting manager initially agreed that training had not taken place to equip staff with the knowledge to recognise these incidents respond appropriately if they did take place. We asked the provider for further details and were informed that these areas were included in staff's induction training which was carried out to the care certificate induction standard by external trainers.

We also examined records which showed that CCNE were supporting people who had a diagnosis of mental ill health. Some people were described as being at 'medium risk' of 'self-harm' (injuring themselves) if left alone. We found there was no specific accredited training that had been undertaken by all staff which gave them the skills and insight into supporting people with mental ill health including those who were likely to self-harm. We found there was no best practice guidance available or used by the service in relation to people with mental ill health such as Guidance from the National Institute for Health and Care Excellence (NICE) guidance: 'Self-harm in over 8s: long-term management Clinical guideline.'

We found some people who used the service required support to manage their diagnosis of epilepsy. However there was no indication that best practice guidance had been considered such as from the National Institute for Health and Care Excellence (NICE) entitled 'Epilepsies: diagnosis and management Clinical guideline (cg137) Published date: January 2012 which explains the advice about the diagnosis and management of epilepsy in children, young people and adults.

This meant that persons providing care or treatment did not have the qualifications, competence, skills and experience to do so safely and measures to mitigate the risk to people using services were not in place.

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

We found that some staff were supporting the personal care needs of children. We found there was no specific accredited training that had been undertaken by all staff working with children such as an understanding of children's rights / young people's consent issues or training in child protection. We did not find any best practice guidance or any reference to The Children Act in any of the provider's documents we saw. The acting manager agreed with our findings

The acting manager confirmed that a new commercially available educational software package was being used which was desk based training and courses with an external training organisation provider were being planned. We found that the registered provider recorded details of training undertaken by staff on paper in their personnel records, and on the provider's electronic computer record. The acting manager explained that they were presently updating their training records so that these would show which training staff had undertaken and plan further courses. The acting manager also confirmed that training records continued to be held in this way which made it difficult to tell which training had been undertaken and which were required.

We looked to see how the provider made sure that staff had the support and supervision from senior staff in the organisation to make sure that individual performance was acceptable. We looked at staff supervision and training records and we found that staff were carrying out 'self-appraisals' to identify issues. When we looked at these records we found that they were not all dated to indicate when they were completed and there were no records of any completed actions as a result.

When we looked at supervision records we saw that a number of supervision meetings had been carried out recently and that they had identified issues with staff. No actions had been recorded as a result of a supervision meeting with any staff. We found actions which should have been undertaken as a matter of priority. For example we found within the supervision records that a member of staff was working without any form of identification and this had been found in August 2016 and again in November 2016. The acting manager told us that the person had not been given their identification badge. This meant that staff had been working in people's homes without verifiable identity and this had been known by the providers' acting manager. This was an issue which was found in the last inspection of April 2016.

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

We examined the care records (held in people's homes and copies at the providers' office),of a selection of five people who were using the service we found four people who did not have a written record of consent which agreed that CCNE would provide personal care services. One of the four people was a child where the service should have had consent from their parent or other legal guardian as appropriate. The acting manager agreed that a record of consent was not always in place.

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

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

before a deprivation can take place.

We checked whether the service was working within the principles of the MCA. The acting manager told us that no authorisations from the Court of Protection were in place or presently under consideration for any of the people that were being supported by the organisation and that discussion would take place with the referring social worker if there were any concerns.

Requires Improvement

Is the service caring?

Our findings

When we spoke with staff they told us that they 'would always contact the office' or 'tell their supervisor' if urgent or significant occurrences had taken place. However we met with one person who had equipment in their home which was broken and therefore the staff were unable to support them with their planned care. Staff had made two visits without informing senior staff that they could not carry out their support role. We also found other examples where incidents had taken place and staff had made records in care files but no actions had been taken as a result. The acting manager told us that management had not been made aware of these incidents. This showed that staff approaches did not always support people's autonomy and independence and ensured the health and well-being of people using the service.

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

Not everyone had positive experiences of the service and we found some people were dissatisfied with the care they had received from staff. One person said, they come and go as they like and do what they want – I think they just suit themselves." When we checked the amount of time that staff had spent with this person we found that staff had stayed for less hours per week than had been arranged and they had paid for. We brought this to the attention of the acting manager and made a safeguarding adults alert to the local authority to protect this persons wellbeing.

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

We did not find that information about people's background such as, personal history, preferences, interests or the subjects they liked to talk about not were generally recorded in care records. This would have helped staff to get to know people quicker and give staff a greater understanding of their experiences.

When we visited some people in their homes they were complimentary about the staff who supported them and their positive relationships with their carers. One person told us, "I love these girls - they are my friends I would not want anything to happen to them - I know their families." Another person said, "They respect me and I respect them – we know where we stand with each other."

There was evidence to show that some people felt empowered to contact the provider when they were unhappy or where they wanted changes to be made. One relative told us, "If we don't get on, I tell them (the provider) and I will get another company." Another relative told us, "The bosses aren't so good but the lot that come to your house are spot on."

There was evidence that planning took place when people used or moved between different services or agencies. Where possible people or those that mattered to them were involved in these decisions and their preferences and choices were respected. There was an awareness of the potential difficulties people faced in moving between services.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in April 2016 we found the registered provider was in breach of Regulations 9 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Whilst we found the registered provider had made some improvements at this inspection we found continued Breaches of Regulations which affected the safety of people using the service.

When we visited the services offices we looked at individual's records to see how their care was planned, monitored and co-ordinated.

We looked at the way that people's care needs were assessed and understood by the registered provider. For three people, their needs had been assessed by the person's social worker (sometimes called a care manager) so the provider could identify the specific support and assistance people needed. These were written in a way which placed the person at the centre of their care and support routine which emphasised their preferences (sometimes called 'person centred'). We found that some people had a record of a meeting that had taken place with senior staff from the service. Their needs had been recorded as a list of questions / answers relating to tasks to be carried out by staff. These were not written in a person centred way. We also found that the provider had a 'Provision of Care' document for everyone who used the service. The acting manager told us this was a summary of the care to be provided. These described the support people were to receive as a list of tasks such as, 'Has a catheter insitu may need assistance,' Administer medication from dosset box.' Most of the records we looked at had no date recorded so we could not tell if they had been updated when people's needs had changed. Another person had a record called a 'Service User Tasklist' which had entries such as 'Apply creams (as required),' Bed call make sure bed is lowered in case she falls,' 'Provide drink.' None of these were written in a person centred way, nor gave specific details on how to care for the person.

We found one person who was receiving personal care without an assessment of their needs having been carried out at all. The assessment of needs on record related to another householder who was linked to, but not in receipt of personal care from the service. The acting manager told us this was because of the way the service had been requested by the local authority. This meant the service had not carried out with the person an assessment of their needs and designed care to meet their personal requirements.

This is a Breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found some people's assessments did not include important aspects of their care. For example we saw that some people suffered from epilepsy and staff were supporting them to take medication regularly. But care records did not contain a risk assessment or care plan plans which would minimise risk and guide staff member's practice in the event of them having an epilepsy incident.

We looked at the arrangements the provider put in place where people needed support to help prevent skin pressure damage. We found some of the records the provider had made were contradictory. For example

one person's care records stated that their skin condition was 'healthy' but that they also described as 'currently got (skin) abscess in (XX) area.' This placed them at risk of poor treatment or care because the guidance to staff in care plans did not provide a clear understanding of this persons needs and how they should be treated.

We examined records which showed that CCNE were supporting people with a variety of needs including people who had mental ill health. Some people were described as being at 'medium risk' of 'self-harm' (injuring themselves) if left alone. However care plans to guide staff practice and determine the actions they would take should a person indicate or actually carry out self-harm, were not in place. There were no care plans which described the actions and approaches to use to avoid or reduce the likelihood of self-harm and there was no planned therapeutic approaches which would support the wellbeing of people with fluctuating mental ill health.

Guidance from the National Institute for Health and Care Excellence (NICE) guidance: 'Self-harm in over 8s: long-term management Clinical guideline' states 'A risk management plan should be a clearly identifiable part of the care plan and should: address each of the long-term and more immediate risk, address the specific factors.. include a crisis plan...and ensure that the risk management plan is consistent' The acting manager confirmed that the service did not utilise any best practice guidance for staff or managers, staff supporting people who are likely to self-harm had not received specific training about how they should support people with mental ill health and care plans did not include specific information which could be used to recognise and guide staff practice should an incident take place. This meant people were at risk of receiving unsafe or inappropriate care.

This is a Breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at one person's care record which indicated that staff were to administer a controlled drug, measure their blood oxygen saturation levels and records their pulse rates. We looked at their care plan records which stated that staff from CCNE were to administer controlled medication each morning and night and records were to be kept. However the acting manager could not find any record of when these had been administered in the providers' records. There were no records available which clarified why oxygen saturation levels and pulse rates were being recorded. The acting manager sought clarification from other staff. They informed us that the person no longer required controlled drugs or oxygen therapy but staff continued to record oxygen saturation levels and pulse rate as this had been requested by family members. The acting manager agreed that the care records needed to be updated to reflect these changes.

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

We checked complaints records. This showed that procedures were in place and had been followed when complaints were made. The complaints policy was seen on file and the acting manager when asked, could explain the process. The policy provided people who used the service and their representatives with information about how to raise any concerns and how they would be managed. Some people we spoke with told us they would approach the provider if they had a complaint. One person said, "I will just ring (the registered provider) up and ask him to get it sorted." Another relative told us, "We are given the formal complaints procedure by the owner but if you're not happy - ringing the office is the best bet – they're very good at sorting things out."

Inadequate

Is the service well-led?

Our findings

At our last inspection in April 2016 we found the registered provider was in breach of Regulations 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found continued Breaches of Regulations which affected the safety of people using the service.

At the last inspection the registered provider gave us documents which made reference to the provider having been awarded a quality award of 'ISO 90001' by external verifiers. However they were unable to demonstrate that these quality standards remained in place at the service.

At this inspection we looked again at the way the registered provider assessed monitored and improved the quality and safety of the service.
We looked for evidence that monitoring of the service took place in order to assess the quality and safety of the services provided and make improvements when required. The acting manager told us that a 'Home care service user survey' was used to get feedback to from people using the service. We looked at a sample of fourteen surveys that had been returned and found some people had made positive statements such as, "They always ask (name) opinion on everything" and "Staff go over and above what is expected." However we saw two records where people had negative views about the service they received. The acting manager told us that these would have been dealt with by the senior staff in each area. However there was no evidence of any actions taken as a result of this feedback.
We looked at the providers' arrangements to monitor the administration of medication for people who use the service. The acting manager showed us records where staff had been monitored by senior staff when some of the gaps in medication records had been noted. However the acting manager was unable to demonstrate any actions taken as a result of these findings. This meant that the providers' systems for monitoring and mitigating risks to service users had been ineffective.

We looked at the agreements people had made with the provider for the services received and found four people out of a sample of five did not have a signed agreement to indicate they had consented to the support offered by the provider.

We looked at arrangements to ensure that people were receiving the services they were expecting and were paying for. We sampled the timesheets of staff who had visited two people who used the service and found that both had not received the amount of staff time they had paid for. The acting manager told us that they were unaware of the shortfall. This showed that systems to monitor the performance of the service were ineffective and placed service users at risk of not receiving a service they needed, agreed and paid for.

The acting manager confirmed that the results from the audits had been assessed or analysed to identify where improvements could be made; and there was no subsequent programme of improvements. They confirmed that there was no management plan for the service which would demonstrate the present situation and strategies which were to be put in place to improve the quality of services.

We found that there was no effective system or process in place to assess, monitor and improve the quality

and safety of the service provided. Effective systems to seek and act on feedback from relevant persons for the purposes of continually evaluating and improving were not in place.

When we asked for care planning records for some people, these were not available. We were told by the acting manager these were being stored at the provider's home address. Some people's care plan records were unavailable for a period of two weeks before we were able to see them. This meant that peoples care plans were not available for staff to use for reference and to update important issues about people's care.

During our inspection we looked at financial records for one person who was subject to financial protection from the local authority. Financial Protection is to assist people who are unable to manage their own financial affairs and have no-one that will take on this role for them. We found that there were no receipts kept for transactions made and not a complete record kept of the person's finances The person's recent financial records were not always completed appropriately and the policy in place for staff to follow was not clear. This meant that the person was not always protected from financial abuse.

This meant that an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided had not been maintained.

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

Following the last inspection of April 2016 the provider sent us an action plan which stated how improvements would be made. One of the areas of improvement was to ensure people were safeguarded from abuse or improper treatment. The provider told us a 'Log to be retained in a safeguarding file.' Prior to this inspection CQC was informed by the local safeguarding authority of an incident involving a member of staff from CCNE whilst on duty. The acting manager told us that a record had not been made and kept in the safeguarding file as described in the provider's action plan.

After the last inspection of April 2016 the provider sent us an action plan which stated how improvements to ensure relevant 'Statutory Notifications' would be made. A Statutory Notification is where there is a legal requirement to share information with CQC. At this inspection we found that the registered provider was offering services to support Children without having submitted legal Notification to CQC that the providers' 'Statement of Purpose' now included this service user group. A Statement of Purpose is a legal document which is required to accurately describe the registered provider's areas of operation.

The acting manager was also unable to demonstrate how the provider had ensured that legislation in relation to children such as The Children Act 1989 (and subsequent related legislation) were implemented or that measures to protect and uphold the UN Convention on the Rights of the Child were in place. We did not find links to legislation in relation to children in any of the provider's policies. The acting manager agreed with our findings.

At the last inspection in April 2016 we found the provider had moved the registered location from the address at Belgrave House without ensuring that registration with CQC at the new address had taken place. At this inspection we found the provider had again not met the requirements of their registration and had failed to apply to CQC to notify of the change of address.

This is a Breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

In the providers' staff handbook it gave the name of one of the providers as the registered manager of CCNE. At the time of our inspection there was not a manager in place who had been assessed by CQC as having the skills, qualifications, knowledge and experience to be the registered manager of the service. There had been no registered manager at the service for over nine months. The registered provider had appointed an acting manager who had been in post for three weeks prior to our inspection. The registered provider told us the acting manager was able to support the inspection.

The provider advertised on their website that the service was CCNE was a 'City & Guilds Approved Centre of Specialist Care Training.' However when we contacted City & Guilds we found the provider was not an approved centre of specialist care training as they were describing. The registered provider subsequently agreed that CCNE was not approved by City and Guilds and that this should have been removed from the website as it was misleading.