Assist Domiciliary Care Limited

Choose Your Care

Inspection report

Silverdale Care Home
Newcastle Road
Newcastle under Lyme
Staffordshire
ST5 6PQ

Tel: 01782618357

Date of inspection visit:
06 October 2016

Date of publication:
28 December 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 6 October 2016 and we gave the provider 48 hours' notice. This was to ensure that someone would be available in the office as it is a domiciliary care service. The service has not been previously inspected. At the time of our inspection there were approximately 67 people using the service with a range of support needs such as dementia, physical disability and older people.

There was no registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The service was not consistently safe. There were safeguarding incidents that we were made aware of that had not been reported to the local safeguarding authority in order to protect people who used the service. Not all staff were aware of what constituted abuse and not all staff had undertaken safeguarding training. Staff had not always recognised when abuse was occurring.

Risk assessments lacked detail and often there were no mitigating plans in order to reduce the risk for people and staff. Some people had support needs which had not been taken into account in the risk assessments, such as equipment used for mobilising and help to keep skin healthy.

Medicines were not always managed safely. People who required support with their medicines did not always have this recorded within their care plan and risk assessments and there was information missing from some medicine records so there was a risk of staff not giving medicines as prescribed. There were also no protocols in place for medicine that were 'as and when required' (PRN) so this put people at risk of not having their medicines when they needed them.

There were not always enough staff so that people received the amount of support they needed, with staff they knew and at the time they expected. Some calls had been planned to take place at the same time and date as other calls so staff were expected to be undertaking two visits at the same time on occasion.

Staff were not always sufficiently trained. New staff did not have a formal induction process and were taught whilst accompanying other staff members whilst out on calls. Staff told us they did not feel that the training they had received was enough to help them be effective in their role to care for people safely and well. This also did not equip them with the skills to provide training for new staff members.

Plans were not in place to provide guidance for staff about how to manage behaviours associated with

caring for people who became anxious when support was provided. This put both people and staff at risk as staff were not always aware of how to support people effectively.

Staff did not feel fully supported in their role and not all had received supervisions to ensure they were effective in their role. Staff had limited opportunities to discuss their own training and development needs.

Mental capacity assessments were not consistently carried out and some of those that had been carried out had not been completed correctly. Checks regarding relative's legal authority to make decisions on a person's behalf had not been made so people's legal rights were not being protected. People and staff confirmed that people were supported to make their own decisions and consent was gained before staff gave support. Therefore not all of the principles of the Mental Capacity Act 2005 (MCA 2005) were being consistently followed.

People told us they were regularly asked for their opinion about the service they received but they often would not get a response or the concerns they had raised would not be addressed. Therefore improvements were not made based on feedback from the people who used the service.

Concerns were not always reported by staff and the service had not identified these issues through their quality monitoring systems. Quality monitoring systems were not fully implemented and minimal auditing had taken place. Although some issues had been identified, they had not yet been addressed.

People and relatives did not always know who the manager was and felt they had not always responded to feedback. People told us they knew who other senior members of staff were at the service and they were able to approach them.

People found staff treated them with dignity and respect and when people had regular staff that visited them, they were able to build up a relationship as staff got to know them. However, people were often visited by staff they did not know and care plans lacked detail to support these other members of staff to meet people's preferences. People told us that they were encouraged to be independent and staff would explain the support they were offering, so people knew what was happening, as it was happening.

Recruitment practices meant that appropriate checks were in place to ensure staff were fit to work with people who used the service. This involved checking with the Disclosure and Barring Service (DBS) for criminal records, getting references from previous employers and checking identity documents.

Most people we spoke to were supported by relatives to make their meals throughout the day.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

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

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected from harm because staff were not aware of different types of abuse and how to report concerns.

Peoples' medicines were not always safely managed and people had not always had their medicine as prescribed.

There were not always enough staff to support people's current assessed needs. Care was not always provided at the agreed times.

Safe recruitment practices were followed to ensure appropriate staff were working with people who used the service.

Is the service effective?

Inadequate

The service was not effective.

Staff were not supported and did not have the skills and knowledge to support people effectively.

Peoples' consent was gained and people were encouraged to make decisions where possible. However, evidence of Lasting power of Attorney and mental capacity assessments had not always been completed.

Concerns about people's health were not always reported in a timely manner which caused a delay in getting healthcare advice.

Most people were supported to eat by their relatives, however for some people it was not clear why they had their food and drink consumption documented.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Regular staff knew people well however other staff did not know people as well and plans were not in place to ensure people received care that met their needs and preferences.

People told us they felt involved in their care planning.

Privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not responsive.

People did not have their needs fully considered and reviews of care plans and risk assessments were not in line with the provider's own guidelines.

People knew how to complain although concerns were not always addressed.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager in post.

Effective systems to review the quality and safety of service provided were not in place to identify issues and improve the service

People did not know who the manager was and felt their concerns were not always addressed.

Choose 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 was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6 October 2016 and the provider was given 48 hours' notice because they provide a domiciliary care service; we needed to be sure that someone would be in. The inspection was carried out by one inspector.

We looked at information we held about the service including statutory notifications submitted. Statutory notifications include information about important events which the provider is required to send us by law. We also asked commissioners and Healthwatch if they had any information they wanted to share with us about the service. Healthwatch is an organisation that gathers information from people and relatives who use services and provides feedback to commissioners and regulators (like the CQC) about those services.

We spoke with six people who use the service, eight relatives, six members of staff that supported people and other professionals that have contact with the people who use the service. We reviewed the care plans and other care records (such as medication records) for eight people who use the service and looked at management records such as quality audits. We looked at recruitment files and training records for five members of staff.

Inadequate

Is the service safe?

Our findings

People were not protected against the risks of potential abuse. Staff we spoke with told us they had not always had safeguarding training and some staff were unable to tell us about the different types of abuse. They all told us they would report concerns to their manager if they suspected someone was being abused, however due to some staff's lack of knowledge about what constituted abuse, this meant there was a risk of abuse not being recognised and reported. When we spoke with staff some told us of incidents that should have been reported to the local safeguarding authority for the incidents to be looked into, however when this was followed up with the local safeguarding authority, this had not been done. Records also showed that not all staff had the necessary safeguarding training. One staff member we spoke with said, "I've not had safeguarding training, other than on the job." This meant people were not being protected as when incidents had occurred they had not been reported and action had not been taken in a timely way to keep people safe.

These issues demonstrated a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not being protected against identified risks and action had not been taken to prevent the potential of harm. There were some risk assessments in place for people, to help keep them safe however they did not contain enough detail. Some would identify a risk but there would be no plan for the staff to follow in order to minimise that risk. For example, in two people's files we looked at, it was recorded that they needed support with their mobility and that they used equipment to help them move around their homes. However their risk assessment did not identify this equipment or how staff should use the equipment in a safe way to minimise the risk to the person. In another person's file we saw in the risk assessment that they were at risk of falling. There was no detail as to what staff should do to help minimise the person's risk of falling. One relative we spoke with said, "[Relative's name] has falls but Choose Your Care haven't really done anything to reduce [relative's name] falls." Another relative we spoke with described an incident whereby the staff had used poor moving and handling techniques and their relative had not been comfortable whilst using equipment. This meant people were not being protected against risks as there were no plans in place to reduce the likelihood of a risk occurring.

In one person's care plan we saw that they needed support to monitor and maintain their skin integrity. A plan had not been written and guidance for staff about what to monitor in order to help the person keep their skin healthy was not in place. This left the person at risk of their skin becoming damaged as staff did not have the guidance as to what to do.

Medicines were not always managed safely. Some people's risk assessments stated that they did not have support from staff with regards to their medicines. However, the provider had not taken into account that topical medicines, such as creams, are a medicine and staff involvement with medicines should be clearly documented and instructions provided. We saw that staff regularly supported people to apply their creams, however there were no specific plans in place to guide staff on when or where they needed to apply these

creams. This meant people could not be assured they were getting their creams as prescribed as there were no specific instructions for application.

Some medicine is applied or taken as and when required, called 'PRN medicine'. There were no protocols in place to help staff identify when a person may need or not need their PRN medicine. When we asked the manager about these plans they were unable to provide any and they did not think they had any plans. This means people were at risk of not receiving their medicine when they needed it or receiving it when they did not need it as there was no guidance for staff to follow.

Medication Administration Records (MARs) are used by staff to record when they have administered or not administered a person's medicines. Staff we spoke with described how they complete a MAR per month by using the previous month's MAR as a template and the medicines actually in the person's house were not necessarily checked to confirm the records were still current. One member of staff we spoke with said, "We just base it on the previous month's MAR". This means that a change in medicines may not be identified as the medicine within a person's home may not be checked and only the paperwork was used as a check. The MAR charts that we checked had missing information such as the dosage and it wasn't clear if a medicine was PRN or a regular prescription. The MAR charts were handwritten however one member of staff we spoke with told us, "Sometimes I can't read the handwriting" and they went on to say, "I didn't give [person] their medicine as I wasn't sure what it was". This meant documentation was not always clear for staff to follow which put people at risk of not having their prescribed medicines correctly.

These issues demonstrated a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives we spoke with told us that there was not always enough staff to provide care and support at the agreed times. One member of staff we spoke with told us, "I am expected to pick up extra calls regularly." Another member of staff said, "There isn't enough staff at the moment, they're always asking me to cover calls." One relative we spoke with said, "They seem to be short staffed" and another relative we spoke with said, "They seem to be struggling [with staffing]. They're asked to cover calls and seem overworked" and "It's noticeable that they have not got the staff." Some calls had been planned at the same time as other people's call times which meant that staff would have to fit in extra calls into their rota. This meant some calls were much shorter than they were supposed to be or at a different time. A relative we spoke with said, "The time was regular and then it was 30 minutes late, now it's an hour later and sometimes it's even later, it's pot luck. It interferes with our day". One person we spoke with told us that they had declined some calls because the times offered were not their normal times. A person told us, "It's a bit upsetting [when staff cannot attend calls at the correct time]". Another relative told us, "The staff tell us they have gone to a new customer before visiting us and our call is late because of this, even though we have been receiving care longer". Some people and relatives told us that they had to call up the office sometimes to find out where the staff were, if they had not arrived on time. The provider explained that multiple staff had left without working their notice and this had caused issues in ensuring people got their calls This meant people would not always be receiving the amount of care they needed and at the time they needed it and staff were covering additional calls which could impact upon the timing of calls and lead to the dissatisfaction of people.

These issues demonstrated a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that their regular staff made them feel safe. One relative we spoke with said, "To be honest, I feel my relative is safe if we have the same staff" and another relative said, "I think my relative is safe with the

staff, they tell them everything they are doing and ask if [relative's name] is alright." One person we spoke with told us, "Yes I feel safe, it is just how they are with me that makes me feel safe." This meant that despite some things not being in place, such as risk assessments and abuse not always being recognised and reported people still felt safe with their regular staff in particular.

People told us that staff wore aprons and gloves when they were being supported with personal care. One person we spoke with told us how staff followed good food hygiene guidance and washed their hands prior to preparing food. This means infection control measures were being taken to protect people from cross-contamination and keep them healthy.

The service followed safe recruitment practices. Staff files we viewed included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with people who used the service. Records seen confirmed that staff members were entitled to work in the UK as their identity had been checked.

Inadequate

Is the service effective?

Our findings

Staff were not always sufficiently trained. One relative we spoke with told us, "We have had some staff who hadn't been working for Choose Your Care for very long and they had to ask what to do." Another relative we spoke with said, "New staff who had done some shadowing were then training even newer staff, even though they had only just started themselves" and another said, "The new ones need better training." One member of staff we spoke with said, "I don't feel we have enough training." Another member of staff said, "I do not feel the training was good enough" and "I wouldn't say the training is adequate, especially for new starters."

Staff told us they had not had training in certain areas, such as safeguarding and moving handling and what they had learnt had been whilst they were working with another staff member. One member of staff told us, "[Person's name] had a new piece of equipment to help them move but we didn't know how to use it and no training was arranged so the equipment got returned." The piece of equipment was to help the person to turn around when they were standing up, due to mobility issues. This meant that the person was not supported to use the equipment safely and may have continued to have difficulty with their mobility as a result of the equipment having to be taken back. Another member of staff told us, "I've not done any medicine training, I just follow the care plan." This meant people were at risk of not receiving their medicines as prescribed as not all staff had undertaken training to ensure their competence with this.
Training records showed that not all staff had undertaken all of the necessary training before starting working in the community. For example, some people had specialist support needs. From speaking with one relative they made us aware of concerns about how staff were helping a person with their specialist support needs and the records showed that staff had not undertaken training in these areas which meant the person was left in discomfort and in an undignified manner. This meant people were not being supported by staff who had the skills and knowledge to meet people's needs and staff felt they needed more training.

It was documented in some people's care plans that they became anxious or agitated when they were being supported by staff. However, there were no plans in place in order to support staff to help calm a person or help the person to be less anxious. Some of the staff we spoke with told us that there were no plans or guidance for them to learn to assist people effectively. When we spoke with staff some of them told us they had not had any training to enable them to support people who needed extra help to manage their behaviour and there were no plans in place to guide staff to reduce the person's anxiety. One member of staff said, "There are no plans in place to help us calm [person's name] down," and another member of staff said, "There are no plans in place to support [person's name], we are left to our own devices." This meant that if a different member of staff attended, they would not have the information to enable them to support people with anxiety and other challenging behaviour in an effective way. This meant people were not consistently supported to manage their behaviour and anxiety and staff were not trained to support people.

Staff had mixed feelings about how they were supported in their role. One member of staff we spoke with said, "I've not had any supervisions. It would be a useful tool to help me improve or do things differently." Another member of staff said, "I've not had any supervisions." Some of the staff files contained copies of

supervisions and appraisals with staff who had been working for Choose Your Care for a number of months but new staff members had not yet had a supervision. The limited amount of supervisions that had been undertaken and the views of the staff team meant staff were not effectively supported in their role to deliver safe and good quality care to people.

These issues demonstrated a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people we spoke with were supported by relatives to make their meals. In one person's care file we saw that staff had been recording how much a person has had to eat and drink each day; however it was not clear why this was being done and there was no guidance as to how much food and drink that person should be having per day. The amount of fluid the person was drinking was also not totalled so it was not clear how much the person had consumed. This meant staff would not know how much food and fluid to provide for the person and it was not easy to check whether the person was consuming the correct amount for their needs.

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. A person who has Lasting Power Of Attorney (LPOA) has the legal right to make decisions and sign agreement on behalf of someone who has lost their capacity to make their own decisions.

We saw that some mental capacity assessments being undertaken, but not all people who required an assessment had one completed. Of those that had been completed, some had not been completed correctly. Relatives were also signing consent forms and other documentation on behalf of people when their legal right to do this had not been checked. However, when we spoke with people and relatives they told us that the staff checked that they were happy to be supported by them. One person we spoke with said, "They check with me before helping me." Another person we spoke with said, "I choose what I have to eat." A relative we spoke with told us, "They check permission first." Another relative we spoke with said, "Yes, they check with her before supporting [my relative]." Staff also told us that they checked people's consent before supporting them and offered choice, one member of staff said, "I always check with them. I offer people choice such as whether they want a wash or a shower and what they want for their meals". This meant that although people were not having their legal rights consistently protected as stated in the MCA 2005, staff were offering choices and checking for consent prior to supporting a person.

Requires Improvement

Is the service caring?

Our findings

People told us that they had some regular staff and that those staff knew them well; however there were occasions when people received visits from staff they did not know. One person we spoke with said, "My two regular staff know me particularly well but I don't really know the other staff who visit." Another person said, "I used to get copies of the rotas so I knew who was coming, but now I don't" and someone else said, "The staff are always changing" and "We get a lot of different staff." One member of staff said, "Some people have had calls from staff they didn't know and it has upset a few people." One person told us that when a new member of staff had visited with a more experienced member of staff, "they [the staff] talked as if I wasn't there" whilst they were being trained. This meant people were not consistently receiving care from staff they had got to know and were sometimes visited by people that they had not expected to visit their home.

However, overall people's dignity was respected by staff. People and relatives told us the staff were caring. One person we spoke with told us, "They treat me with dignity and respect, very much so. It's their attitudes, I feel comfortable with them." One relative we spoke with said, "They are very caring, I can trust them, I can leave the room when they are here" and "We're on first names terms with my relative's regular carers, the staff know them well." Another relative told us, "They treat my relative as a normal person and not as someone who needs support." All staff we spoke with were able to tell us about how they supported people to retain their dignity and gave examples, such as offering choices and not dismissing those choices, keeping curtains closed during personal care and encouraging people to do as much for themselves as possible rather than staff always doing things for them. Most people were able to confirm that staff used these methods to keep their dignity.

People were given the information and explanations they needed, one relative told us, "They explain things to [relative's name] and hold their hand whilst helping her." A person we spoke with said, "The staff make me feel relaxed." A relative we spoke with also told us, "They always ask how my relative like's things done and they explain things." People told us they felt involved in planning their own care. People were also encouraged to be as independent as possible. One relative we spoke with told us, "The staff encourage [relative's name] to do what they can do." A member of staff told us, "I keep talking to the person, make sure they are ok and check if they are ok." Another member of staff gave us an example, "Instead of using a remote control to move a piece of equipment, I ask if they would like to use the remote control themselves." This meant people were encouraged to retain their independence and do what they were able to for themselves.

Requires Improvement

Is the service responsive?

Our findings

We saw that care plans and risk assessments had not been regularly reviewed, with reviews only being annually. One member of staff told us, "I've never seen a risk assessment updated, I don't think many are updated but they should be." We also saw that in some care plans and risk assessments that certain aspects of people's care had not been included or updated, such as the equipment that was required to enable people to move around their home. One relative told us that there had been occasions when the service had not been able to meet their relative's preferences; they told us that two staff members had been offered to carry out the visits however they were not the usual gender they have, so they did not have the visits. When we asked the manager about the frequency of reviews of documentation, they told us the reviews should be quarterly however this timescale was not currently being met. This meant people may not receive the care they required as reviews were not identifying a change in care needs or if something had been previously omitted.

Most people told us that they were asked for their opinion about their care, however if they told the service about an issue it wasn't always dealt with. People told us they had been asked about their care through surveys or phone calls however they had not always been informed of the action taken and things had not always improved. One relative told us, "I don't feel anything has been done with our comments. We've raised things but they have not been dealt with". Another relative told us, "They occasionally contact me but things have never changed or got better" and "I've fed back but nothing seems to change." In the care files there had been documented phone reviews and reviews where a member of staff had visited people's homes to discuss people's opinions about their care but no follow up action had been documented as to how the issues raised had been resolved.

In one review we saw that a person had raised the fact that they had previously made a complaint but they had not received a response. There was no follow up action documented that this had then been dealt with. Staff also told us that if they had raised a concern that they had not always been made aware of the outcome, one staff member said, "When we complain, we never hear back from it." People and relatives were all able to tell us how they would complain and staff explained what they would do if people wanted to make a complaint to them, however one relative said, "I have my reservations as to whether they would respond to my concerns." We saw some evidence of complaints which had been responded to which had been forwarded to the provider from the local authority, however other concerns not received from the local authority had not always been identified or responded to. This meant people had not always had their concerns responded to and feedback was not always acted upon to improve the quality of care people were receiving.

We saw that concerns, for example about people's health, observed by staff had been documented in people's care notes, but there was no action recorded about resolving any issues. For example, one person was in pain which staff had recorded in their daily notes but this was not documented as being reported to anyone. The person was in pain for a number of weeks before action was documented and they visited a health professional to assist with their pain. This meant that concerns were not always reported in order to

make timely referrals to other health professionals.

Most people and relatives told us they were involved in the writing of the care plans when Choose Your Care first started supporting them. We saw that there were brief details of people's life history available for staff to read in order to get to know people. However, the details of people's daily routines and personal details of their preferences were not always included and only basic task-orientated instructions were included. People and relatives told us that when a new member of staff started, they had to explain things to them, and said, "I feel better if we had the same staff, if we get different ones I have to check what they are doing." If a person was unable to communicate then they would not be able to explain to a member of staff what to do. This meant people may not be getting the care in the way they would like as staff did not have a care plan with their preferences recorded to refer to.

Inadequate

Is the service well-led?

Our findings

This was the service's first inspection since registration.

Quality assurance systems were not fully implemented. Audits of MAR records and medicine records had not taken place. When we asked the manager about this, they explained their plan was to audit 10% of medicine records per month, however due to some care plans and risk assessments not including the correct information about who received support with medicines meant this would not necessarily be accurate. We requested records regarding any medicine errors and any action that was taken as a result of an error. No records were available as the manager did not believe there had been any medicine errors. When speaking to members of staff, we were made aware of errors with medicines which were not recorded on medicine error forms. This meant the quality of people's care was not being consistently checked and improvements had not been made.

The manager was able to show us a small amount of care file audits. These covered a number of areas such as whether a particular document was present in the file and whether a document was completed correctly. When some issues had been identified in the audit, there was no explanation as to what the issues were. Action taken to resolve the omissions they had identified as part of their audit had not been documented so it was not possible to see if the audits had been effective. The manager also explained that the notes held in each person's home used for staff to document what has happened at each visit, are brought into the office when the book is full. However this meant that people who had fewer visits than other people would be audited less frequently and a longer period of time may pass before issues or trends were identified. For example, the care notes we saw had not been audited since the documents had been started by care staff. For instance some people had care note books that had begun at the start of August 2016 and were now back in the office after the books had been filled and they had not been looked at. We identified issues that had not been documented or reported back to the office or manager. This meant that issues were not being identified and timely action was not being taken to improve the care for people.

Telephone reviews had been carried out and a survey had previously been sent out to people and relatives to gather their opinions of the care they were receiving. However, an analysis of the results of the survey and telephone reviews had not been undertaken so no action had been taken with the results. Concerns had been fed back about issues such as different staff attending calls that people don't know and the timing of calls. This meant that the service had not analysed and improved based on feedback from people and people's care not had always improved.

Staff told us they had spot checks to assess the quality of their care whilst they were out supporting people in their homes. These covered areas such as tidiness of uniform, punctuality, how they addressed people and their moving and handling techniques. We also looked at the documented spot checks in some staff files and there were no recorded issues identified. These checks had not identified when staff had lacked training or had needed further support in some areas, which staff told us they needed. That means that although some checks were being done, they did not fully cover areas of improvement required to assist

staff to be effective in their role.
There were not enough staff to effectively meet people's needs due to some staff leaving and there were not enough staff to cover care calls whilst additional staff were being recruited. This meant people did not always receive the care they were expecting at the time they were expecting it. People told us that on occasion they had to contact the office to find out when a member of staff was going to be able to attend.

The provider had not always informed CQC about significant events that they were required to send us by law. This meant we could not be assured they were dealing with incidents and issues in an appropriate way as the CQC was not being informed.

These issues demonstrated a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no registered manager in post at the time of the inspection. Having a registered manager in post is a condition of the provider's registration. The provider told us that there was a manager in place working at the service until a person suitable to apply to become a registered manager could be found. The previous registered manager had not worked at the service since July 2016. Some people knew who the new manager was, but some people were not sure and did not always have confidence the manager would listen to their concerns. One person said, "They don't ring me back" and, "The issues lie with management, not the carers." A member of staff we spoke with said, "They never make time for people" and, "The manager is a number cruncher." One member of staff said the manager did not introduce themselves to people when they started, so people did not know who they were. One person said, "I don't know who the manager is but I go to the senior carer." People and staff said that other senior members of staff were approachable. One member of staff told us, "I go to the senior, they act on everything." We were told that the provider did not get involved with the day-to-day operation of the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Incidents of alleged abuse had not been recognised as abuse by staff and had not been reported. Not all staff could recognise the different types of abuse.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not have sufficient training for them to support people effectively, such as moving and handling, safeguarding and medicines. Staff confirmed they need more training. There were not always enough staff to meet everyone's needs at the correct times. There is evidence of call cramming.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not detailed and often did not have mitigating actions. There were no plans in place to support staff to assist people who became anxious or had challenging behaviour. Care plans and risk assessments did not always reflect the care delivered regarding medication. PRN protocols were not in place. Poor practice was identified by staff.

The enforcement action we took:

The issuing of a Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regular audits had not been carried out. Issues were not being identified and there was no action taken to resolve some issues. Lack of Mental Capacity Assessments and other plans to support staff such as risk assessments, behavioural plans and care plans which reflected the needs of the people.

The enforcement action we took:

The issuing of a Warning Notice.