Apex Prime Care Ltd

Apex Prime Care - Alton

Inspection report

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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

The inspection took place from 15 to 20 November 2018, with office visits on 19 and 20 November 2018. The office visits were announced to ensure staff we needed to speak with were available. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults, younger disabled adults and people living with dementia or mental health needs. Not everyone using Apex Prime Care Ltd receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. The service was providing care to 64 people on the morning of 19 November 2018, 54 of whom were receiving the regulated activity of personal care.

The service was last inspected in October 2016 when it was rated as good in all areas. Following this inspection in November 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.

Following the inspection the provider submitted an application to de-register this location and the management of the regulated activity for people who continued to receive care was transferred to another of their locations.

There was inadequate leadership and governance of the service. The service had seen frequent changes in management and there was a lack of a registered manager which had resulted in inadequate oversight of the service, lack of support for staff and poor quality of care. 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.

There were insufficient numbers of suitable staff to keep people safe and to meet their needs. People reported they had experienced late and missed calls and inconsistency in staffing. Staff had worked excessive hours to provide people's care but the sudden departures of care staff at the end of October and November 2018 had precipitated a staffing crisis. On the morning of the inspection the service had to arrange to hand back 25 people's care packages to Commissioners, to ensure people's safety. The provider had failed to ensure full pre-employment checks had been completed for all staff and that staff had the skills required for their role.

People's medicines were not managed safely. The guidance and record keeping in relation to medicines management meant that the provider could not demonstrate staff provided safe care in this area.

Risks to people had not always been identified, assessed or addressed within their care plans for people's safety. There were not fully effective systems to protect people from the potential risk of financial abuse.

The provider did not have an electronic system in place to monitor when and if people received their care. The lack of an electronic call monitoring system meant we could not identify how many care calls had been missed. There had been a failure to identify and report missed calls to the local authority under safeguarding procedures as acts of neglect. The provider could not demonstrate people had always been sufficiently supported to ensure they ate and drank sufficient for their needs.

Staff had not all had the opportunity to update their training to ensure it remained current. One staff member was still rostered to provide people's care although some of their training had expired in 2015. Staff had not all received supervision at all this year, which put people at risk of receiving ineffective or unsafe care.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice.

People did not consistently receive person centred care that fully reflected their needs and preferences. People's care had not always been regularly reviewed and their care plans updated accordingly. People's needs for accessible information had not always been identified. There was a lack of written information for staff to refer to about who was receiving end of life care.

There had been a lack of management oversight to monitor, assess and mitigate potential risks to people and staff from the provision of the regulated activity. Issues with the standard of care plans and staff recruitment had been identified at the start of 2018, but there had been a lack of effective action to address them for people. There had been a failure to effectively record, investigate and monitor people's complaints or to identify trends.

People's care needs had been assessed prior to the provision of their care and the provider had obtained commissioner's assessments of people's care needs. However, the provider was not able to consistently demonstrate people's care and treatment had been delivered in line with legislation and current guidance to achieve effective outcomes for people.

There was mixed feedback from people and their families about how caring the staff were, some said staff were kind whilst others felt they were treated as a job rather than a person. People's records did not consistently demonstrate what decisions they had been involved in by staff about their care. People's privacy and dignity had been upheld.

There was not an open culture within the service. There was a culture of staff working excessive hours and staff had failed to alert senior management of the extent of the issues at the service, feeling they should cope themselves. There had a been a failure to alert external services with regards to the issues related to staffing to enable them to act to ensure people's safety.

Processes were in place to seek people's views on the service they received and staff's views on the service. Staff were happy working for the provider.

The risks to people from acquiring an infection were safely managed. There were examples of how staff had contacted healthcare services for people.

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 has deteriorated to inadequate.

There were insufficient numbers of staff to support people to stay safe and to meet their needs. Some people's care had to be handed back to Commissioners on the morning of the inspection as there were insufficient staff to meet the care hours the service was commissioned to provide.

People's medicines were not managed safely, and records of the support people received with their medicines were not sufficiently robust to ensure peoples' safety.

Systems, processes and practices were not operated effectively to protect people from the risk of financial abuse.

Risks to people had not always been identified, assessed or addressed within their care plans for people's safety.

Is the service effective?

Requires Improvement

The service has deteriorated to requires improvement.

The service did not ensure all staff had the skills, knowledge and experience required to deliver effective care. One staff rostered to provide people's care was not up to date with their training and not all staff had received supervision this year.

Where people lacked the capacity to consent to their care legal requirements had not consistently been met to safeguard their human rights.

The provider could not demonstrate people had always been sufficiently supported to ensure they ate and drank sufficient for their needs.

The provider was not able to consistently demonstrate people's care and treatment had been delivered in line with legislation and current guidance to achieve effective outcomes for them.

Is the service caring?

Requires Improvement

The service has deteriorated to requires improvement.

People did not consistently report that staff were kind and caring.

There was not always written evidence to demonstrate people had been involved in decisions about their care.

People's privacy and dignity had been upheld.

Is the service responsive?

Requires Improvement

The service has deteriorated to requires improvement.

People did not consistently receive person centred care that fully reflected their needs and preferences. People's needs for accessible information had not always been identified or met.

There had been a failure to effectively record, investigate and monitor complaints to identify possible trends and address them for people.

There was a lack of written information for staff to refer to about who was receiving end of life care.

Is the service well-led?

Inadequate

The service has deteriorated to inadequate.

There had been a lack of sufficient management oversight to monitor, assess and mitigate potential risks to people and staff from the provision of the regulated activity.

There was no registered manager in post as legally required and leadership of the service was poor.

Staff had been running the service on a day to day basis and they were not fully skilled and competent to manage the challenges that have arisen.

There was a poor working culture where staff worked excessive hours and did not seek help as required to ensure people's safety.

Apex Prime Care - Alton

Detailed findings

Background to this inspection

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

This inspection was completed between 15 and 20 November 2018. We made telephone calls to people who use the service on 15 and 16 November 2018 and visited the office to speak with staff and review records on 19 and 20 November 2018. This inspection was completed by two adult social care inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience had experience of caring for older people.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

Prior to the inspection we received feedback from a Commissioner of the service. During the inspection we spoke with seven people and four relatives by telephone. We also spoke with five care staff, the deputy manager, the Regional Manager and the Regional Trainer for the service.

We case tracked two people which is when we speak with the person or their relatives and review their care plans, medicine records, staff rosters and daily records. We reviewed the same types of records for a further four people. We also reviewed staff recruitment and supervision records for three staff and staffing rosters for four staff.

The service was last inspected in October 2016 when it was rated as good in all areas. We identified seven breaches of Regulations at this inspection.

Inadequate

Is the service safe?

Our findings

People were dissatisfied with the staffing of the service. They told us there was a lack of consistency in staff, calls were often late or missed and that calls were not always of the length commissioned. Their feedback included, "It's always different faces, there's no one regular so I never know who I'm getting. There's never a call if they're late. It makes life very difficult, you don't know where you are." "In theory we have an agreed time for the morning visit, but they are often early or late with no warning. "

The service was commissioned to provide 400 hours of care per week to people on the morning of the inspection. The provider's information return submitted on 18 November 2018 stated there were 18 staff. However, there were only 11, this number included part-time and bank staff. Three care staff had left suddenly at the end of October 2018. Records showed people had only received a service due to staff working excessive hours.

The staffing rosters for one care staff showed they had worked every day for the 28 days up to 18 November 2018 without a break. This was despite it having been agreed with them at their supervision on 8 August 2018 that they should have one day a week off. The rosters for another staff member showed in the 31 days up to 21 November 2018 they had one day off. In addition to their full-time office hours, they had also had to work extra hours delivering care to people, on some occasions this was up to an additional five and a half hours per day. The provider had not complied with the legal requirements of the Working Time Regulations 1998, as these staff had not received the legally required one day off per week. This demonstrated that the provider did not have sufficient numbers of staff and had placed people at risk of receiving unsafe care due to staff being excessively tired.

The provider did not demonstrate they had an effective plan in place to mitigate risks associated with staffing shortages. There was a further crisis in staffing on 16 November 2018 when two staff left without giving notice and a third member of staff went sick. Commissioners were not alerted, and the decision was made that there were sufficient staff to cope. As a result, two people who required personal care did not receive their care that weekend. When we arrived for the first day of the inspection, one person had rung in that morning to say staff had not turned up. Office staff covered this call, but it was delivered late and no-one had turned up to provide a second person's care. It was only when we asked senior management and office staff what action they were going to take to address the situation for people's safety that Commissioners were contacted. The provider then agreed with Commissioners to hand back 25 people's care packages, including that of 17 people who received the regulated activity, as they had insufficient staff to provide these people's care. This action ensured people were now safe.

The failure to ensure sufficient numbers of staff were deployed to provide people's care safely was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not managed safely. There was insufficient guidance for staff to ensure people received their medicines as prescribed and records of medicines administration were not completed accurately in a way reflecting best practice. People who were prompted by staff to take their medicines did

not have a medicine administration record (MAR), to guide staff about what medicines they were to prompt people to take and to provide an accurate record, as per national guidance, of what medicines the person had been prompted to take. This placed people at risk of receiving their medicines unsafely. Records for two people we reviewed did not contain an up to date list of the medicines they took, as per national guidance, therefore; staff lacked information about what medicines they were to prompt people to take, which left them at risk of receiving unsafe care.

One person's care records did not demonstrate which medicines they had been prompted to take; their care notes just stated, 'meds' or 'meds taken' or nothing was written. This person's relative told us, "Half the time [person's name] isn't prompted to take [person's name] evening medicines." The provider could not demonstrate this person had received all their medicines as prescribed. One person being prompted to take Warfarin, which requires careful management for the person's safety, did not have a MAR, staff only completed the person's 'yellow' book which is their record of their Warfarin management. When we asked staff why the person was being prompted to take their Warfarin in the morning rather than the evening when it is usually given, they told us the morning care staff, 'knew what they were doing.' The safety of this had not been checked. We asked for this to be checked and staff spoke to the person's GP. Staff also needed to speak with the person's pharmacist and there was no record of who this was on file, to enable this information to be accessed quickly; senior management advised us this would be done for the person's safety and we alerted Commissioners. Following the inspection, senior management rung us to confirm this guidance had been sought, to ensure this person's medicines support was provided safely.

Where people had MAR sheets which had been printed by the service, we found gaps in staff signatures. The provider could not demonstrate whether people had received their medicines as prescribed on these dates. When staff had to add additional medicines to the MAR sheet, the entry was not countersigned by two staff as required by good practice guidance to ensure the information had been safely transcribed. There was no written guidance for staff with regards to medicines people took, 'as required,' to enable them to know when people might need these medicines, or how frequently. This left people at risk of receiving these medicines unsafely. There was no written guidance for staff about the application of people's topical creams to enable them to know how much to apply, where and how thickly; good practice is for this information to be provided visually on a bodymap. There were no risk assessments for when staff were instructed to leave medicines out for a person to ensure this practice was safe. People did not receive their medicines safely.

The failure to ensure people received their medicines safely was a breach of Regulation 12 Safe Care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not effective systems to protect people from the risk of financial abuse. The provider's financial policy was not sufficiently detailed to guide staff around procedures and risks associated with supporting people with their money. There had been a safeguarding incident in August 2018, which is currently under police investigation. As a result of that incident, a new financial policy was issued to provide clearer guidance for staff. A further incident occurred in October 2018, which related to a person who did not receive the regulated activity and therefore did not come within the scope of this inspection. However, the incident demonstrated the actions taken following the first incident had not been sufficiently robust and people had still been placed at potential risk of financial abuse. The service now only supports one person with their finances and we found their financial records were complete and had been checked. The provider was not able to demonstrate sufficient learning had taken place to ensure all staff fully understood their responsibilities and duties when managing people's finances to protect them from the potential risk of financial abuse.

The provider did not have effective systems in place to monitor people's care calls had taken place. We

found gaps in a person's care records, which indicated that either their care calls had been missed or the records had not been completed. The absence of an electronic call monitoring system meant we could not establish if these calls had been missed, although, their relative confirmed calls had been. We also found evidence in another person's records of missed calls. We spoke to staff who told us there could be more missed calls as the provider did not have a system in place to monitor when and if people received their care calls. Staff did not understand that any missed calls should be reported by the service to the local authority under safeguarding procedures as potential neglect and an act of omission to provide the person's care. The lack of a system to identify all missed calls and the lack of understanding of the need to report them as potential safeguarding alerts and then notify the Care Quality Commission had left people at risk of not receiving safe care.

The failure to safeguard people against the risk of abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People whose records we reviewed all had an environmental risk assessment, which covered risks in their home. No-one provided with personal care at the time of the inspection required hoisting for transfers or two staff to move them. Senior management told us everyone should have a moving and handling assessment. The purpose of this was to identify if people potentially had any moving or handling needs which could then be addressed for their safety. We could not see this assessment for the people whose care we reviewed. People also required a bathing assessment if assisted with this aspect of their care, however, we could not see this assessment. Therefore, we could not be assured any potential risks to people in relation to these aspects of their care had been assessed and mitigated for their safety.

Risks highlighted in Commissioner's assessments of people's care needs had not always been addressed. Commissioners had highlighted falls as a potential risk for one person. There was a lack of evidence to demonstrate how the provider had assessed this risk to the person or addressed how the risk to them would be managed in their care plan. Information about potential risks to people was not always available for staff. For example, one person had a sensor beam on their bed. Incident reports demonstrated staff were a point of contact if the alarm went off, but there was no mention of it in their care plans, to ensure staff were aware of it and how they should respond. A person had an oxygen machine in their home, which can be a fire risk. However, there was no risk assessment in place, as required by the provider's policy, to provide staff with safety guidance. This demonstrated that the provider had failed to fully assess, monitor or mitigate these risks.

The provider did not have effective systems in place to ensure incidents were used as learning opportunities. We saw evidence of incident forms and actions taken to prevent the risk of repetition for people. However, incidents had not always been reported. A person's care notes showed there had been an incident on 7 November 2018 and the ambulance service had been called. There was no incident form and when we spoke to senior staff they told us they had not been informed. Care staff had failed to report this incident to enable a review of the incident for the person's safety.

The failure to ensure potential risks to people were assessed and managed safely was a breach of Regulation 12 Safe Care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's recruitment processes were not always robust. One staff file reviewed did not contain photographic proof of the staff's identity or evidence of a full employment history. There was a not a satisfactory written explanation for any gaps in their employment history. The provider had not ensured full pre-employment checks had been completed upon this staff member or that an explanation had been

provided for any gaps in their records to ensure their suitability to work with people.

The provider's recruitment checks did not always identify if staff had the key skills required to support people. People reported a member of staff had poor English, which affected their ability to communicate effectively with people. Their comments included, "I have one [care staff] who comes who doesn't speak a word of English, so we don't understand each other. It's useless." A relative said to us their loved one was, "Really frightened of [a care staff], they couldn't speak English so couldn't converse." This issue had not been identified or addressed at the point of this staff's recruitment although they have now been offered help, their lack of English had impacted negatively on people's experience of the care provided.

The failure to ensure full pre-employment checks had been completed and that staff had the skills required for the role was a breach of Regulation 19 Fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received infection control, training and had access to the providers guidance. A staff member told us, "We have gloves and aprons from the office." One person told us, "They are very particular about wearing gloves," whilst another commented "They don't always wear gloves and aprons when helping with personal care." Overall the risks to people from acquiring an infection were safely managed.

Requires Improvement

Is the service effective?

Our findings

The provider did not ensure all staff had the skills, knowledge and experience required to deliver effective care. One person said, "Some are well trained but not all of them. We had problems because I have a catheter and none of them knew how to change the leg bag. It's better now and I get staff who know how to do it." Another person said, "I had one young girl came who didn't know how to empty the commode and was a bit aghast that she was expected to do that. I had to show her how to do it."

Staff confirmed they had completed an induction to their role. The provider's induction covered the standards required by the Skills for Care 'Care Certificate,' which is the standard industry induction for staff new to the care industry. However, senior management told us there was no-one at the location who was qualified to assess staff's practical skills to enable them to fully complete the practical requirements of the Care Certificate. Therefore, staff did not have the opportunity to finish this training

The provider required staff to update their training annually. Although the majority of staff were up to date with their training requirements records showed for one member of staff, five areas of their training had expired in August 2015 and a further eight in October 2017. The only area of their training they were up to date with was moving and handling. This staff member was still rostered to provide people's care. They were rostered on 26 occasions between 1 October and 19 November 2018 to provide care to a person living with dementia who required prompting with their medicines. This put the person at potential risk of receiving unsafe care as the staff member had not had the opportunity to update their medicines training.

Staff did not receive consistent ongoing support and development in their role. Staff had not received supervision at the frequency required by the provider whose policy stipulated staff should receive two supervisions per year. Supervisions are an opportunity to review the quality of staff's working practice and identify ongoing training needs. Six staff had not received any supervision of their work this year. People's care was provided by staff who had not received sufficient supervision to ensure they received effective care.

The failure to ensure staff had received sufficient training and supervision to undertake their role was a breach of Regulation 18 Staffing 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.

One care plan reviewed was not signed by the person nor was there a mental capacity assessment and best interest decision to determine the person lacked capacity to make the decision to accept the care provided and that the provision of care was in the person's best interests. We spoke with staff, who confirmed they

needed one. Senior management told us the staff member responsible for these assessments had completed MCA training twice this year. We saw evidence of a completed MCA assessment for another person, but it was for two decisions, whether the person could consent to the provision of personal care and food and fluids. MCA assessments are decision specific and should relate to only one decision. Legal requirements had not always been met when people lacked the capacity to consent to their care and not all staff understood the application of the MCA, to ensure people's human rights were upheld.

The failure to act in accordance with legal requirements where people lacked the capacity to consent to their care was a breach of Regulation 11 Need for Consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans did not reflect how staff could meet their nutritional needs. A Commissioner's assessment of a person's care needs, stated they needed their breakfast, lunch and tea prepared for them. Their care plan did not instruct staff about the risks to that person or inform staff that they should prompt them to eat and drink. There was inadequate written guidance for staff about what support they were to provide for this person to ensure their nutritional needs were met and the care plan did not reflect the care commissioned with regards to meeting their nutritional needs.

Staff visited a person living with dementia twice a day to provide personal care and support. Although staff were commissioned to ensure the person remained as independent as possible with meals, it was not clear from their daily records they were receiving sufficient nutrition. Some, but not all, daily record entries demonstrated staff had checked what the person had eaten during the day. It was not always clear they had received adequate nutrition. On 31 August 2018 records showed the person had fruit for breakfast and snack foods for dinner, there was no record that staff had checked what they had for lunch. On 3 September 2018 there was no record of any food they had eaten that day. We noted that on several mornings the person just ate fruit. It was not clear from their records whether this was their choice or what staff offered them as it was quick. There was a lack of information for staff about the person's dietary needs and preferences and the actions they should take if they were concerned about their intake. The person's relative told us, "Sometimes [person] tells us [person] had a banana - like it's an easy afterthought on the way out of the door." The provider could not demonstrate from their records this person had eaten sufficient for their daily needs and that their nutritional intake had been adequately monitored by staff at each care call, so any concerns could be identified, reported and actioned.

The failure to identify and mitigate risks associated with people's nutritional needs was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care needs had been assessed prior to the provision of their care and the provider had obtained Commissioner's assessments of people's care needs. However, the provider was not able to consistently demonstrate people's care and treatment had been delivered in line with legislation and current guidance to achieve effective outcomes for people. Although staff had access to the provider's policies, they did not always reflect best practice. The provider's supervision policy did not reflect National Institute for Clinical Excellence (NICE) guidance on the supervision of home care workers, to ensure they received sufficient supervision of their work. This states they should receive supervision every three months. Although a member of staff had been provided with training updates and support by senior management to provide them with additional knowledge and skills, it was not clear that they were consistently applying the guidance and tools provided to ensure effective outcomes for people.

There were examples of where staff had communicated incidents and raised issues with the office staff. We

saw examples of where staff had contacted healthcare services for people. However, as highlighted in other areas of the report, incidents had not always been communicated to more senior staff and external services had not always been kept updated about events which had placed people at risk of unsafe care.

Requires Improvement

Is the service caring?

Our findings

There was mixed feedback from people and their families about how caring the staff were, some said staff were kind whilst others felt they were treated as a job rather than a person. One relative told us that on the morning of our call the office had phoned them to tell them that they had arbitrarily moved the time for their relative's care call that morning because, "She [office staff] had something else to do." This relative did not feel the person was valued. The same relative told us a member of staff had walked out half way through providing their relatives care on another day. Another relative said, "I refused one carer who was argumentative." Another person said, "Some of them [staff] are extremely helpful but others are off hand and make me feel like I'm just a job to be done."

Three people and their relatives told us it was difficult to build relationships with staff due to the lack of consistency in care staff allocated. Their comments included, "We are trying to get a regular girl to do the morning visit when I have personal care as it's not nice having different faces." "It's lots of different carers and we have asked for one member of staff because [person] has dementia - to provide continuity but it hasn't happened yet." Between the 4 November and 18 November 2018 this person had eight different care staff deliver their two care calls per day. Another person said, "The carer's keep changing - there's no continuity and when you're blind that's not easy." People would have preferred or benefited from having their personal care being delivered by care staff who they felt they had got to know. The care provided did not provide them with the continuity they required or take into account their protected characteristics of age or disability as defined by the Equality Act 2010. The providers policy, 'Expectations of the care service,' stated people should expect to be provided with regular care staff wherever possible, but this had not happened.

There was travel time built in between people's care calls, but people felt that staff were too rushed to have time to spend with them. One person said, "They don't chat, they just do things quickly and leave." Another person told us, "The staff are run ragged." A relative told us, "The carers write down the times they come and leave but sometimes they've only stayed 10 minutes others 25." This person was supposed to have two 30-minute calls per day. We noted from their daily records in June 2018, care staff had not stayed the full allocated time, although this had improved since July 2018 and the times recorded now covered the full 30 minutes.

There was written evidence people had contributed to their care planning process. However, staff had not always asked people to sign their service user plan where they had the capacity to do so, which would have provided a written record of their involvement and agreement with the content. People's care records did not consistently demonstrate what decisions they had been involved in by staff about their care.

Staff were provided with training on privacy and dignity as part of their induction and refresher training. Staff understood how to uphold people's privacy and dignity when providing their personal care. One told us, "Give privacy, closing the door, (check with person when) ready to be seen when washing, and respect." People's privacy and dignity had been upheld.

Requires Improvement

Is the service responsive?

Our findings

People told us they were involved in their care planning. Feedback included, "I do remember that they talked the care plan through with me when I started having help from them and "my daughter discussed the care plan with the manager when they started."

There was a lack of background information about people, beyond that provided by Commissioners in their assessment of the person's needs. People's care plans were not always fully person centred; they did not always provide sufficient information about how the person wanted their care to be provided. One person's care plan stated they liked to have a chat before they started to get ready for bed, but there were no prompts for any staff new to the person's care to indicate what interested them to start a conversation. This person's provider assessment and service user plan said their right arm was weak, but there was no record of how this impacted upon the person and the provision of their care. Another person's care plan stated they had poor mobility, but their care plan did not reflect how this might affect them during the provision of their care. People were at risk of receiving care that did not meet their needs.

People's preferences about their care were not always documented. A person's social worker had emailed the service in May 2018 to inform them that even though the person did not want to shower daily care staff were still insisting on this happening. Staff were instructed to update the person's care plan, but there was a lack of evidence to demonstrate this had been done. The person's care plan did not reflect they may not want a shower, nor did it provide instructions for staff about what to do if they declined. This person's care plan did not fully reflect their preferences. Another person told us, "I have asked if they could just feed me, it would be such a help" and "Staff say they are not allowed to feed me because it maintains my independence. If they would just help feed me." This person wanted assistance with eating, but there was no mention of this in their care plan, only for staff to heat their meals. People's preferences were not always documented in their care records and as this person's daily records were not available for our review, the provider could not demonstrate they had received sufficient nutrition for their needs.

Staff had not always established what people's health related conditions were to ensure the provision of their care fully reflected their needs. There was no mention in a person's care plan about them living with dementia. It was important to establish this person's diagnosis so that staff with the correct skills to meet their needs could be rostered to provide their care. It was also important to inform staff, in the person's care plan, of their diagnosis and any related behaviours they might exhibit to aid staff's understanding of how to respond to them. Another person told staff at their review in September 2018 that they were hard of hearing and they wanted all their care provided in their room, but their care plan had not been updated with this information and was dated June 2016. Their care plan had not been updated to reflect their new preferences and needs. Where people's health care needs were known, there was not always relevant written guidance for staff. A person had a diagnosis of type two diabetes, but there was no information in their care plan for staff about how to recognise the signs to indicate that they may be becoming unwell or the actions they should take. People's care plans did not always identify all of their needs or how to meet them.

Whilst one person's records we reviewed showed their care had been reviewed in March 2017 and September 2018, not everyone's care had been reviewed as required by the provider. The provider expected that people's care should be reviewed at periods of six weeks, six months and then every 12 months after their service commenced. Systems were in place to enable the service to track when reviews were to be completed, however, there was a lack of evidence to demonstrate this had been effectively used to ensure people received their reviews as required.

Records for one person showed they had commenced their service in April 2018, but there was no record to demonstrate this person's care had been reviewed at either six weeks or six months as required. Another person's care had commenced in September 2014. We only found evidence of two reviews, one in February 2017 and another which their front sheet in their records stated took place on 3 April 2018 and the client review form gave a conflicting date of 21 April 2018. This person's care had not been regularly reviewed between 2014 and 2017. A third person's last review of their care on record was March 2017; their care had not been reviewed this year. People's care had not always been regularly reviewed.

The service did not ensure that people always had access to the information they needed in a way they could understand it and thereby, comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Although senior management had introduced an accessible information assessment to identify people's communication needs, staff had not used this consistently. Staff were unaware a person was registered as partially sighted and had therefore not offered them information in an accessible format.

Staff had not received training in end of life care to enable them to understand how to support people and their families at this stage of their life. The assessment Commissioners had provided for a person, clearly stated they were receiving palliative care from an external service, but there was no mention of this in the person's care records, to inform staff. Although care staff we spoke with were aware of this information, there was no written information to guide any staff unfamiliar with this person's specific support needs.

The failure to provide care that reflected people's preferences and met their needs was a breach of Regulation 9 Person-centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's complaints policy stated people could make a verbal complaint. Five people told us they had made complaints about the service. One person told us, "We've made lots of complaints because they just aren't doing their job. Some of the office staff are helpful but they always say, we're working on it - but nothing changes." Another person said, "I have complained about the care worker who doesn't speak English but whether they will listen and make permanent changes I don't know." We checked this person's staffing roster and noted the staff member was still rostered to provide the persons care, we found no written acknowledgement of their verbal complaint. Another person said, "They did take the carers I complained about off our visiting list, but I think they didn't like it."

The complaints file contained no written complaints. Senior management told us they had introduced a, 'concerns file' where verbal complaints should be listed and addressed for people. Although we saw evidence of concerns that had been raised, we could not see records or acknowledgement of the complaints made by the people we spoke with. The provider was unable to demonstrate that the system to log and address verbal complaints for people had been fully effective at capturing and addressing all issues raised. Although two people told us staff had been removed when they complained about them. The provider was not able to demonstrate people's verbal complaints had been recorded and audited for trends and areas of

risk, such as whether the same staff were involved in these complaints.

The failure to assess, monitor and improve the service on the basis of people's feedback was a breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The provider had failed to take effective action to keep people safe in the event of ongoing staff shortages. There had been a failure to identify when the three staff left at the end of October 2018 the potential risk to the service's ability to continue to provide all people's care safely. There was a failure on 16 November 2018 to acknowledge that there were not sufficient staff to cover people's calls that weekend and to seek assistance from Commissioners at that point to ensure peoples' safety. The systems to identify staff's availability and to use this information to evaluate the capacity of the service to meet their contracted hours was not used effectively to ensure there were sufficient staff to meet people's needs. There was a lack of provider oversight of the number of hours staff were working in order to provide people's care. There was no monitoring of the number of hours staff worked in order to mitigate risks to people and staff. There had been a lack of management oversight to monitor, assess and mitigate potential risks to people and staff from the provision of the regulated activity.

The systems to monitor the quality and safety of the service were inadequate. There were audits completed of people's medicine administration records (MAR) and daily care records, however these were inconsistent. There was a process in place for managers to log if staff had returned these records each month for auditing as required, but it had not been used. Therefore, we found no care records had been returned for a person in November 2018. Another two people's care notes did not demonstrate they had been audited for completeness. One person's care notes for November 2018 had been audited on 13 November 2018 but the auditor had not checked to see if the incident noted by staff on 7 November 2018 had been reported and an incident form completed. An opportunity was missed to check the required actions had been taken to keep this person safe. A person's MAR for August 2018 had not been audited until 6 November 2018, two months later. This showed numerous gaps in the application of their topical creams, which are applied to protect peoples' skin from breakdown. As the audit had not addressed these gaps the provider could not demonstrate if the person had received this care. It also demonstrated the provider was not addressing issues with individual staff members about poor recording. Staff could not locate this person's MAR records for September or October 2018 for us to review and to check if they had received their topical creams as prescribed. Peoples' records should be readily accessible so that details of the care provided can be reviewed.

The providers quality assurance was ineffective in driving and sustaining improvement. We saw the last manager's action plan for the service dated 12 January 2018. This demonstrated the service required improvements in relation to care planning and recruitment and the aim was to achieve this within three months. The previous senior manager had completed an audit of the service in May 2018 and this had been reviewed by the new senior manager at the beginning of October 2018. It identified issues with auditing people's daily records, the standard of care plans, a lack of moving and handling risk assessments, lack of reviews and a lack of information about people. These were the same issues we identified at this inspection. These issues had previously been identified, however, there had been a lack of effective action to address them for people.

The lack of oversight to monitor, assess and mitigate potential risks to people and staff from the provision of

the regulated activity or to maintain accurate records was a breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a lack of strong, consistent leadership within the service. There was no registered manager for the service. There had been a registered manager from 16 June 2014 whom senior management told us was dismissed, and they de-registered on 17 November 2017. A new registered manager was brought in from another branch, but they had to manage two branches, the other of which was rated as Requires Improvement in July 2018. They de-registered in June 2018, as a new manager had been appointed, before they applied to re-register, as the new manager had then decided not to take up the post. The manager then left the service without working their notice on 23 October 2018. This left staff to run the service. Senior management told us at the start of the inspection that the service, "Was not led strongly enough by local management" and that a, "Strong registered manager was required to lead and guide." There had been insufficient strong, full-time leadership of the service and responsibility for the day to day running of the service had lain with office staff.

Staff leading the service day to day had not felt supported by the two previous managers of the service and we saw little evidence of any input from the previous manager. They had received an induction to their role, but our findings from this inspection demonstrated they lacked the knowledge and skills required to run the service independently in the absence of a registered manager. Therefore, when issues with staffing started to escalate, they were unable to speak out and request assistance, instead they just kept going. They reported that they had been told by the previous managers, "Head office don't listen." However, they recognised that senior management had tried to support them since the last manager left, through being physically present at the office and the provision of training, support and guidance.

There was not an open culture within the service which meant that senior management were not always aware of issues relating to quality and safety. Senior management told us there appeared to be a culture of the staff working excessive hours and not reporting fully or openly about what was happening within the service. The staff member leading the service who had worked under both of the two previous managers of the service confirmed there had always been a culture of, "Covering the work if carers could not" by staff at the location. They had not alerted senior management on 16 November 2018 that two staff had handed in their notice early that morning. They had then been optimistic in their assessment of the team's ability to cover people's care that weekend. The closed culture had resulted in a lack of awareness of the full extent of the issues within the service by management.

Staff liked working for the provider despite the excessive hours some worked. Their comments included, "Happy with Apex" and "Nine times out of ten, able to see (deputy manager)."

People's views on the service were sought if they had received a review. People had been sent the last quality survey in April 2018 and 17 people responded. The feedback received was very positive and no issues were identified with the care provided at that point. Staff views were sought through staff meetings the last one of which was held on 23 August 2018. Processes were in place to seek people's views on the service they received.

Staff running the service day to day reported they had a good working relationship with Commissioners. However, the provider had not forged effective working partnerships with Commissioners. They had not acted transparently when concerns arose which meant that Commissioners could not implement contingency plans when the providers staffing issues escalated. This resulted in people receiving unsafe care.