Athlone Care Ltd

Athlone Care

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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 7 and 8 June 2017 and was announced. Athlone Care provides care and support to a wide range of people living in their own homes including, older people, people living with dementia, and people with physical disabilities. The support hours varied from one half an hour call a day to four calls a day, with some people requiring two members of staff at each call. At the time of the inspection 50 people were receiving care and support from the service.

The service had a registered manager in post. A registered manager is a person who is 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.

We last inspected Athlone Care in May 2016 when two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. We issued requirement notices relating to safe care and treatment and good governance. We made multiple recommendations including recommending the provider considered reviewing staffing levels to ensure that people's needs were being fully met and recommending that the provider ensured staff had a clear understanding of The Mental Capacity Act 2005 and how this needs to inform care.

At our inspection in May 2016, the service was rated 'Requires Improvement'. We asked the provider to take action and the provider sent us an action plan. The provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. We undertook this inspection to check that they had followed their plan and to confirm that they now met legal requirements. The provider had not met the previous breaches of regulations and further breaches were found.

There was a lack of scrutiny and oversight by the registered manager to ensure that people received safe care and treatment. Staff documented that people had fallen or had visits from health care professionals in people's daily notes but did not call to inform the office so that any follow up action could be taken. The management team did not regularly review people's daily notes so they were unaware of changes to people's support or incidents that occurred and did not follow them up to ensure that appropriate action had been taken.

People's care plans did not contain the detail needed to keep people safe including guidance for staff about how to reduce the risk of pressure sores. One person had developed a pressure sore and although staff had asked the person's relative to contact a district nurse, they had not informed the office for over three days. They had not recognised the development of a pressure sore could be a potential safeguarding issue. Another person had become unwell and staff had told their relative to contact a doctor for advice. This had not been reported to the office, so the management team were unable to monitor and assess if appropriate action had been taken.

Some people needed assistance with eating and drinking. One person told us that they had specific dietary needs to help manage their health condition. This was not recorded in their care plan and the registered manager told us they were 'unaware' of this person's needs. Care plans also lacked information on how to support people to move safely or remain independent. People's care plans had been sampled and checked by the registered manager, but these checks had not identified these shortfalls.

People's medicines were not always managed safely. Staff did not consistently record when they administered medicines. Medicine records had not been reviewed or checked by the management team, so these issues had not been identified.

Staff reported accidents and incidents to the office however, the management team did not review them to ensure appropriate action had been taken and to reduce the risk of incidents happening again

People and their relatives told us that staff were consistently late when providing support. The provider's analysis showed that in April 2017 over 244 care and support calls to people had been more than half an hour late. The provider had asked for feedback from people, their relatives and other stakeholders involved in the service and this had identified that staff were often late too. People told us they had complained when staff had been late, but there was no record of these complaints at the office. Without a record of these complaints and the themes and outcomes, there was a risk that the registered manager would not be aware of them and therefore, not use this to improve the service.

Staff did not follow the principles of The Mental Capacity Act 2005. Some people's relatives had signed to consent to the care provided by the service, even though the registered manager told us that these people had capacity to consent themselves. Some people were documented as being 'confused' but there had been no assessment of their capacity and no advice for staff on how to support people to make decisions.

People did tell us that staff were kind and caring, and when they offered support treated them with respect and dignity.

All staff were working towards completing The Care Certificate, which is an identified set of standards that social care workers work through based on their competency and vocational diplomas in Health and Social Care. They had received additional, online training in topics relating to people's needs such as dementia. Staff had received 'spot checks' when supporting people to assess their skills and competencies. The registered manager had ensured that staff were recruited safely and that the Care Quality Commission had been notified of events, as required by law.

Staff told us they knew how to recognise and respond to abuse and what action they would take to report any concerns. However, staff had not reported potential incidents of neglect, such as the development of a pressure sore to the registered manager.

We found a number of 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 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.

Medicines were not managed safely.

Not all risks to people were assessed and guidance was not available to make sure all staff knew what action to take to keep people as safe as possible. Senior managers did not monitor incidents and risks to make sure the care provided was safe and effective.

People and their relatives said that staff were consistently late when providing their support.

Staff told us they knew how to recognise and respond to abuse. However, did not always report possible instances of neglect to the management team.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always report concerns to the office when people became unwell.

There was a lack of guidance for staff to ensure they assisted people to eat and drink safely.

The principles of The Mental Capacity Act 2005 were not always followed. People's relatives had signed to consent to their care when they had the capacity to do so themselves.

Staff had received spot checks and had training relating to people's individual needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us that staff were kind and caring and treated them with respect and dignity.

There was a lack of information for staff on people's life history and backgrounds and how to encourage them to remain independent.

People and their relatives were involved in initially planning their care, but there was a lack of information for staff to ensure this ongoing involvement.

Is the service responsive?

Inadequate

The service was not responsive.

People's care plans did not contain necessary guidance to ensure staff gave the personalised care and support people needed.

Care plans had not been reviewed and updated when people's needs had changed.

Complaints were not always recorded, investigated or responded to in line with the provider's policy.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not taken appropriate steps to ensure they had oversight and scrutiny to monitor and support the service.

The provider had not ensured that the requirement notices from the previous inspection had been complied with.

People were at risk because systems for monitoring the quality of care provided were not effective. Records were not suitably detailed, or accurately maintained.

Notifications had been sent to the Care Quality Commission, as required by law.

Athlone 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 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 took place on 7 and 8 June 2017 and was announced. The provider was given 48 hours' notice because the location is a domiciliary care agency and we needed to be sure that someone would be at the office. The inspection was carried out by one inspector and an assistant inspector.

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. Before the inspection we reviewed all the information we held about the service, we looked at the PIR, the previous inspection reports and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law. We reviewed questionnaires that had been sent to people, their relatives and professionals involved in the service.

We spoke with the registered manager and the business manager of the service. We spoke with six members of staff. We looked at eight people's care plans and the associated risk assessments and guidance. We looked at a range of other records including five staff recruitment files, the staff induction records, training and supervision schedules, staff rotas and quality assurance surveys and audits.

We visited people in their homes and spoke to them and their relatives about the care they received.

We last inspected Athlone Care in May 2016 when two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. At this inspection, there were two continued breaches and four additional breaches of the regulations.

Inadequate

Is the service safe?

Our findings

People told us they felt safe when staff were supporting them. One person said, "I feel safe, that's all you can ask for, isn't it?" Another person said, "I think it is safe, I have the same 'girls' come in and see me, and they seem to know what they are doing." One person had commented, 'Staff are good, they always do their job well and look after me. I am happy with the service. I like them and feel safe.' Although feedback was positive, we identified issues regarding medicines and risk management and people were not always supported safely in their homes.

At our previous inspection in May 2016 the provider had to failed to protect people from the risks related to medicines management. Staff were administering medicines without being trained to do so and did not record individual medicines administered on a medication administration record (MAR). At this inspection staff had now received training on how to administer medicines but medicines were still not administered or managed safely.

Staff did not accurately record when they administered people's medicines. We visited one person in their home. They told us that staff administered their 'pain patch' each night. We reviewed the task list for staff, which stated, 'Carer to stick patch on [person's] back.' Care staff did not record on the MAR that they had applied the pain patch or the time they placed the patch on the person's back. We requested further information about the patch from the registered manager, after the inspection. They told us the patch should be applied, '1 per day for 12 hours per day.' They told us that the person usually removed the patch themselves; however, none of this information was documented in the person's care plan. We sought advice from a specialist pharmacy inspector, who told us, '[Name of medication] directions usually are apply once daily for up to 12 hours, followed by a twelve hour plaster-free period, it should have been recorded on a MAR because it is a prescribed medicated plaster and a record should be kept of what time it was applied and removed so that the directions above could be adhered to.' Without this record staff could not be sure that the person had a twelve hour plaster free period.

We visited another person and their relative told us, "[Staff member] is marvellous; they administer all of [my loved one's] medicines every morning." The person's care plan stated that staff should 'prompt' the person to take their medicines and had not been updated to show that staff were administering the person's medicines fully. There was a MAR in the file at the person's home. Staff had written, 'blister pack' and then signed to show that the person's medicine had been administered. Staff had not recorded the individual medicines the person received as required.

The registered manager and office staff did not consistently check MARs to ensure they had been completed accurately and that people received their medicines when they needed them. One double sided MAR sheet was dated October 2016. Staff had written 'antibiotic' at the bottom of the back page and 'AM' 'tea' and PM' in one box, on both sides of the MAR. This had been initialled inconsistently so there was no way of knowing what 'antibiotic' the person had been prescribed and if it had been given when needed or if the course had been completed. This was not safe or in line with current practice.

People were not receiving their medicines as prescribed. The provider had failed to ensure that people were receiving their medicines safely. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection in May 2016 the provider had failed to protect people from identified risks. Risk assessments had not been completed correctly and did not contain guidance for staff on how to mitigate risks. At this inspection no improvements had been made.

Some people remained in bed and were identified as being at risk of developing pressure sores. Care plans stated, 'Care workers to monitor skin for any pressure areas and report back to the office.' There was no further guidance available for staff on how the skin may appear if a pressure sore was developing or what action to take to minimise the risk of sore skin developing, such as turning the person at each visit.

One person's daily notes referred to a person having a 'pressure area.' We asked the registered manager and business manager when this had developed and what action staff had taken. They were unable to give us this information at the inspection. The business manager told us they believed the pressure sore was a 'grade two sore' and that the, 'district nurses were monitoring the person's skin.' However, they were unable to provide any evidence to support this.

After the inspection we requested this information again. The business manager told us that the pressure sore had been noted in a person's daily notes, and staff had asked the person's relative to contact the district nursing team, however, the office had not been informed until three days later. Staff had not recognised the seriousness of a pressure sore developing and had not reported it to the registered manager or office staff so they were able to ensure the person was receiving the support they needed.

Risk assessments were not always completed accurately, and did not represent people's true level of need. One person told us that they had fallen several times in their home. Staff had documented in the person's daily notes that they had fallen in March 2017, yet their moving and handling risk assessment, completed in May 2017, stated they had no history of falls.

There was a lack of guidance for staff to follow when people needed assistance to move safely. One person had been assessed as having, 'restricted mobility.' The task list for staff stated, 'support me when I am mobilising.' However, there was no guidance for staff on how to support the person safely, or what kind of support they required. Another person's care plan stated, 'Help [the person] to go down stairs' and, 'Ask them if they would like a walk up and down the living room for a bit of exercise, make sure you support them at all times.' There was no guidance for staff on how to assist the person down the stairs or how to 'support' them whilst walking. Staff worked independently when supporting people, without supervision, and there was a risk that without clear guidance people could receive unsafe support.

Staff did not consistently record when people fell or if accidents and incidents occurred. We reviewed people's daily notes and identified that one person had fallen in March 2016. We spoke with the registered manager and the business manager regarding this fall and they were unaware that it had occurred. They had not reviewed the person's daily notes, and staff had not notified the management team of the fall. There was a risk that accidents and incidents were not recorded and reported by staff and that any delayed injuries as a result of an accident may not be linked to the actual incident. The registered manager would not have accurate information to monitor for trends and patterns to reduce the risk of them re-occurring

When incidents had been reported the management team did not review them to ensure appropriate action had been taken and to reduce the risk of incidents happening again. In April 2017 a person's bath chair had

broken, whilst staff were assisting them to use it. Staff had documented this in the person's daily notes and on an incident form. The registered manager and business manager were unaware this incident had occurred, over six weeks later. They had not taken any action to ensure the person was safe and the bath chair was fit for purpose.

Care and treatment was not provided in a safe way for people. The provider did not have sufficient guidance for staff to follow to show how risks to people were mitigated and not all potential risks had been assessed. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to staff when entering people's homes were assessed. For example, if it was poorly lit or there were trip hazards. The risks were assessed and staff tried to reduce them as much as possible

At our previous inspection in May 2016 we recommended that the provider considered reviewing staffing levels to ensure that people's needs were fully met. Professionals told us that there were not enough staff and that they had received complaints about missed or late calls. At this inspection, improvements had not been made.

People told us that they had to wait for staff and that staff were often late. Some people told us they felt that staff timings had improved recently, but everyone we spoke with agreed there was still room for further improvements. One relative had commented in the provider's quality assurance survey, 'Problems arise when carers are late. The office never answer their phone. [One carer] always texts me when they are running late. Bad communication but seems slightly better lately. I get the impression that carers are stretched at times and better co-ordination may be appropriate.' One person told us, "When you wait for half an hour or an hour, it can get a bit fraught."

There had been occasions when only one member of staff had assisted a person, even though they required two staff, because staff would not wait for a second person to arrive.

The provider kept logs of calls which were more than half an hour late. During April 2017 there had been over 244 calls that had been more than half an hour late. For the week beginning 30 April 2017, 51 calls had been more than half an hour late so people did not get the support they needed at the time they wanted it.

The registered manager told us that they were recruiting more staff. They were also introducing a new electronic monitoring, rostering and recording system to make it easier for staff to check in at each of their calls. They said they felt this would ensure they could guarantee staff would arrive punctually to provide support to people. We will follow this up at our next inspection.

Staff were not deployed effectively and people did not always receive the care they needed at their allotted time. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they knew how to recognise and respond to abuse. They were able to tell us the signs of physical and mental abuse and what action they would take if they had safeguarding concerns. However, staff had not reported potential incidents of neglect, such as the development of a pressure sore to the registered manager. The registered manager and business manager did not regularly review people's daily notes so were unaware of potential instances of neglect, such as the inaccurate administration of people's medicines. When incidents had been reported there were no systems and processes in place to ensure potential safeguarding incidents were followed up.

The provider had failed to ensure there were systems and processes in place to adequately monitor potential safeguarding incidents. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in May 2016 we recommended that the provider reviewed gaps in employment history during the recruitment process. At this inspection some improvements had been made. Staff were now recruited safely. Written references were obtained and checks were carried out to make sure staff were of good character and were suitable to work with the people. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Requires Improvement

Is the service effective?

Our findings

People told us that they felt staff supported them effectively. One person told us, "I have a regular team who come in and help me now, they know me, and I think they know what they are doing." A relative told us, "[Staff member] is just fantastic; I would not have anyone else supporting my relative." The provider showed us feedback which stated, 'There are two or three individuals from the agency who are exceptional carers.' Although the feedback was positive there was a lack of oversight by the management team, which meant there was a risk people's needs would not be fully met and there was a lack of information for staff to follow regarding people's healthcare and dietary needs.

One person's relative told us that their loved one had recently been unwell. They said, "[My loved one] was in hospital for eleven days, they were very poorly, they had fluid on their lungs and it had to be drained. The relative told us that a member of staff had been present in their home when the person had become unwell and advised them to call a doctor. Although the member of staff had taken the correct action, and the person received the support they needed, this had not been reported to the office. The management team were unaware of the advice given by the staff member and that the person had been admitted to hospital.

Another person received support from a physiotherapist. In March 2017, staff had written in the person's daily notes that they were, 'Waiting for the physiotherapist.' The management team were unaware that the person was receiving support from a physiotherapist as they had not reviewed these notes, and the physiotherapist involvement had not been reported to them. We visited this person and they told us their mobility had improved since the physiotherapist's involvement. They showed us the different mobility equipment they now used, and told us they did not always need to use a zimmer frame when moving around their home. There was no guidance for staff on how to support the person now their mobility had increased and there was a risk they may receive inappropriate support as a result.

There was a lack of guidance for staff to ensure they supported people fully when they were eating and drinking. One person's care plan stated, 'Needs assistance with feeding' and, 'Needs special spoons as food keeps on falling when feeding by themselves.' The business manager told us that staff did not assist the person to eat, however staff confirmed that they did sometimes prepare meals and assist this person. There was no information to explain what assistance the person needed or what the 'special spoon' may look like.

We visited one person in their home and they told us that they had to eat a special diet to help manage their medical condition. They told us, "I can only have plant milk and I eat lots of bananas and pears. I have to have special rye bread in the mornings for my marmalade on toast You can only get the bread from certain supermarkets." Staff helped the person to prepare their breakfast and lunch each day but there was no information provided about the person's diet or their medical condition. When we spoke with the registered and business manager regarding this they told us they were, 'unaware' that the person had any specific dietary needs.

The provider did not have sufficient guidance for staff to follow to show how risks relating to people's health and nutrition were mitigated. This was a breach of Regulation 12 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. When people live in their own homes applications to deprive someone of their liberty must be applied for via the Court of Protection. No one was subject to an order of the Court of Protection. We checked whether the service was working within the principles of the MCA.

At our previous inspection we recommended the provider ensured staff had a clear understanding of the Mental Capacity Act 2005 and how this needs to inform care. Some care plans had consent to care and treatment forms signed by people but this was not consistent. At this inspection improvements had not been made. People's care plans were not clear about people's level of capacity. Some people's care plans did not contain any details about how to support people to make decisions.

One person's relative had signed on their behalf to consent to care being provided by the service. The registered manager told us that this person had capacity and that their relative should not have signed for them.

Although staff told us that they asked people for consent before entering their homes and providing support and people told us that staff spoke to them before speaking to their relatives, there were no mental capacity assessments in place. This meant staff had to independently assess people's levels of capacity to consent and make decisions. Some people were confused and disorientated so it was important to assess if they were able to make a decision and give consent or not and to keep this under review. One person's care plan stated they, 'often got quite confused.' There was no of guidance for staff about what support the person would need. There was limited information to show that people's mental capacity had been considered, what ability they had or what support they may need to make decisions.

We recommend the provider reviews and adheres to the principles of the Mental Capacity Act 2005.

Staff told us they felt they had the training they needed to carry out their roles. There was an ongoing programme of training which included face to face training and online training. All staff were working towards completing the Care Certificate, which is an identified set of standards that social care workers work through based on their competency. The provider told us this would ensure that all staff had an understanding of their role and what it involved. Additional competency checks were completed relating to moving and handling. Staff were not supporting anyone who currently needed the use of a hoist, although some people remained in bed and staff told us they knew how to turn people safely. Although staff had received medicine training and their competency was also assessed when administering medicines, they did not always administer medicines safely.

Staff completed additional online training, in topics such as mental capacity and safeguarding. Although staff had received training in these areas they did not always recognise when they needed to escalate incidents or report changes in people's needs to the management team. The management team completed regular spot checks on staff to check how they were supporting people.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were kind and caring. One relative said, "We are so happy with [staff member] that comes to us. They are kind and caring. They always listen to what we have to say. All of our family know who they are, and it does not feel like a stranger coming into our home." Their loved one said, "I agree, I'm happy with the support [the staff member] provides." Another relative had commented, '[My relatives'] carers do an excellent job, they carry out their duties well and are kind [to my loved one.] We as a family are very happy with the service provided.'

Some people told us that they had regular staff and had built up relationships with them. They said the staff were familiar with their life histories and knew their family. They understood their daily routines, choices and preferences, such as what they preferred to be called and how they liked to receive their personal care. Parts of people's care plans contained information about people and their preferences but this was inconsistent and some plans lacked this detail so staff may not be aware of people's personal histories, personal preferences and people and events that were important to them.

Some people said that they were involved in planning their care and were able to make their own decisions. Others said that they had not been involved but were able to tell staff what they needed. Some people would not have been able to tell staff about the care that they needed. Care plans lacked information to show that people were encouraged and supported to be involved in the care planning and how they made decisions about their care.

Information regarding how to support people to retain their independence was limited. One person's care plan stated, '[Person] is able to do some things themselves but still requires support from the care workers.' There was no information regarding what the person could do for themselves or what support they required. Another person's care plan said, 'Needs full help with dressing. Needs full help with grooming. Unable to cleanse self.' Their care plan did say they, 'Can wash only face and hands' but there was no further information on how to promote the person's independence or encourage them to be involved when receiving support.

People were asked if they preferred male or female staff to support them or if they did not mind. One person told us, "I don't want a young girl coming in to help me, so I'm glad [staff member] is a man. Their relative told us, "It is so important to [my loved one] to have a man. We are so pleased with [carers name] they have become like part of the family. We trust them, and it makes [my relative] feel much more comfortable having a man to help them."

People told us that staff treated them with respect and ensured they retained their dignity. One person said, "They are never rude to me. I would not stand for that. I think I am treated with respect." A relative told us, "[Staff member] definitely treats [my loved one] with respect. They are always polite when they visit and I trust them to do a good job. Staff told us that they always respected people's privacy. One staff member told us, "I always close the door when helping someone to shower and I always close the curtains." Another member of staff said, "I cover people up with a towel if I'm helping them to wash or shower."

Staff told us that most people did not require support to help them make decisions about their care, and those who did were supported by their relatives. No one at the time of the inspection was being supported by an advocate. (An advocate helps people to make informed choices.)

Inadequate

Is the service responsive?

Our findings

An initial assessment was completed before staff started supporting a person, and this and a list of tasks for staff to complete at each call were kept at the person's home and at the office. The registered manager told us that the assessment and task list made up a person's care plan.

Care plans should be personalised and contain a step by step guide to supporting people on each visit, including their preferences, what they could do for themselves and what support they required from staff. However, they varied greatly in detail and all we viewed required further detail to ensure that people received care and support consistently, according to their wishes and that staff promoted people's independence.

Care plans were not personalised with detailed information about people's personal care routines, for example, care plans stated minimal information, such as, 'assist [the person to get up and have a wash/shower', the information did not say what 'assist' meant to the individual or take into account people's medical conditions when they were being supported with their mobility. There was no guidance of how people were being supported to remain independent and show what they could do for themselves. Some care plans did not contain any details of people's personal history so that staff would know about and be able to discuss things that were important to them.

There was a lack of guidance in care plans about how staff should give the right support. Staff had met with a person and their relative and written, '[The person] sometimes does get aggressive when they think that no one is listening to them' and, 'The person will get angry.' There was no guidance for staff on how the person may present when they became 'aggressive' or 'angry' or how they should respond to diffuse the situation. Another person's care plan stated they could become 'anxious at times.' There was no information regarding what may cause the person to become anxious or how staff should offer reassurance to ease their anxiety.

Some people remained in bed and were at risk of developing pressure areas. The risk of developing pressure areas had been identified but there was no plan to show staff how to manage people's pressure areas to minimise the risk of further outbreaks. The care plans did not contain information to inform staff on how to give care to people whose skin may be at risk of breaking down. There was no information about what signs to look for in case sores were developing and what action they should take, like contacting the doctor or community nurse. One person had developed a pressure sore. Staff told us that they did not like to be turned. However, the business manager told us, 'the care workers are continuing to reposition [the person] as she is being cared for in bed.' There was no information about how people should be positioned or what equipment may be needed to prevent their skin from deteriorating further.

In April 2017 a relative had written on one person's daily notes, 'Please can [my relative] have a bath every other day. They have not had a bath for over two weeks.' We reviewed the person's daily notes for May and they did not show the person having a bath every other day, as their loved one had requested. We discussed this with the business manager and they told us they were 'not aware' that this request had been made or

that staff were not regularly supporting the person to have a bath.

The provider had failed to ensure that care plans reflected people's assessed needs, preferences and remained up to date and that people received person centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had information about how to complain within the care plan folder kept in their home. This information explained how the registered manager would respond and act on any complaints that they received. People told us they felt confident in complaining, or felt a relative would complain on their behalf. One person said, "I always call the office, I like to know who will be coming to support me, they are always happy to give me that information." People said when they had complained action had been taken and the issue had been resolved. However, complaints were not always recorded, investigated or responded to in line with the provider's policy.

A care manager had sent the service details of a complaint on the 10 November 2016 and requested further information and feedback from the registered manager. This was not acknowledged or responded to. The local authority sent a follow up email to this complaint on 16 November 2016, when it was then acknowledged and investigated.

The care co-ordinators showed us emails that had been sent after issues had arisen out of hours. In December 2016 and January 2017 multiple people and their relatives had contacted the on call phone to report that staff had been over two hours late and some people had cancelled their calls as a result. One relative had complained that only one member of staff had visited their loved one, when they needed two members of staff to assist them. These were not recorded as complaints, and although staff had dealt with each issue as it had arisen there had not been any investigation into how these incidents had occurred or how they could be prevented in the future. People and their relatives did not receive any formal feedback from the registered manager regarding the concerns they had raised.

One person told us that they had complained several times to 'the office.' They told us the complaints had been looked into and sorted out and they were now happy with the service they received. Although the business manager acknowledged there had been issues with the timings of some of this person's calls, this had not been recorded or investigated. Without a record of these complaints and the themes and outcomes there was a risk that the registered manager would not be aware of them and therefore, not use this to improve the service.

The provider had failed to ensure that complaints were always documented, investigated and responded to. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our previous inspection the provider was failing to monitor the quality of the service. Audits and checks were not being completed to ensure people's care plans were up to date or relevant risk assessments had been completed and reviewed. This meant that the provider had no way of monitoring or making required improvements to the service. At this inspection the registered manager said they were now completing monthly checks of missed and late calls, complaints and people's care plans. However, their checks had failed to pick up the serious issues we identified regarding risk management, complaints not being dealt with and the management of people's medicines at this inspection.

The registered manager told us that the office was 'paperless' and that all records were held electronically. We reviewed people's daily notes and medication records. These were stored in several boxes in the provider's office. The business manager told us that these had been initially checked by a 'team leader' when collected from people's homes, but needed to be reviewed by someone in the office before being scanned into the computer and then shredded. We found records dating back to October 2016. The care co-ordinators confirmed that these records had not been checked by anyone in the office or a member of the management team. They were not signed or initialled by the team leader, so there was no evidence this paperwork had been checked at any time. The team leader had not identified any issues with this paperwork before bringing it to the office. People were at risk of inappropriate care due to this lack of oversight.

Staff had recorded that people had fallen or had visits from healthcare professionals but the management team were unaware as they had not reviewed people's daily notes. They had not followed up on potential safeguarding incidents, such as a person's bath chair breaking whilst in use or ensured that staff had appropriate guidance to follow when people's needs had changed. The registered manager had not checked that the bath chair was safe to use. People's medicines records had not been completed accurately and there was a risk medicines were not being administered safely, but the management team were unaware as these had not been reviewed or audited.

The management team had not been informed by staff when people had become unwell or developed a pressure sore. People's relatives told us staff had asked them to seek medical advice, but this had not been recorded and as the management team had not been informed they were unable to follow up and ensure that the appropriate action had been taken.

Some care plans had been checked and audited but this was inconsistent and had not identified the many gaps we highlighted regarding the support people needed with moving and handling, their dietary needs or how to manage their behaviours.

The provider failed to ensure that systems were established and operated effectively to ensure compliance with the regulations. The systems and procedures in place to assess, monitor and drive improvement in the quality and safety of people were not effective. The provider had failed to ensure that people were protected against the risks of unsafe or inappropriate care arising from a lack of proper accurate records. This was an

on-going breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection, we recommended the provider ensured customer satisfaction surveys were carried out on a regular basis. At this inspection the provider had asked for feedback, in the form of surveys, from people, their relatives and other professionals involved in the service. These results had been analysed and collated. The provider's analysis stated, 'Issues raised in the survey included lateness and communication.' An action plan had been written to try to address these concerns. However, many of the actions, such as 'structured supervision with staff' and 'management visits to people' were listed as 'ongoing' and there was no target date for completion. We found that staff were still arriving late and that communication between the office and front line staff could be improved.

The provider had installed a new telephone system to record all incoming and outgoing calls. There were also in the process of installing a new care delivery and monitoring system. They told us this would allow them to monitor staff and people in real time. We will follow this up at our next inspection.

Providers are required to display their ratings on their website and at their office location. The rating of 'Requires Improvement' from the last inspection was not displayed at the start of the inspection. We spoke with the registered manager and they printed out a poster showing their rating and put it on a notice board in the downstairs entrance hall to the office. They also updated their website to show their rating.

At our previous inspection we recommended that the provider ensured that team meetings were held on a regular basis. At this inspection improvements had been made. Regular team meetings were now held and the provider used a monthly newsletter to communicate with staff. Changes in policy and procedure were highlighted and summarised so staff were aware of any changes.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had submitted notifications to CQC in an appropriate and timely manner in line with CQC guidelines.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that care plans reflected people's assessed needs, preferences and remained up to date and that people received person centred care.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure there were systems and processes in place to adequately monitor potential safeguarding incidents.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to ensure that complaints were always documented, investigated and responded to.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not deployed effectively and people did not always receive the care they needed at their allotted time.

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 There was a risk people were not receiving their medicines as prescribed. The provider had failed to ensure that people were receiving their medicines safely. Care and treatment was not provided in a safe way for people. The provider did not have sufficient guidance for staff to follow to show how risks to people were mitigated and not all potential risks had been assessed. The provider did not have sufficient guidance for staff to follow to show how risks relating to people's health and nutrition were mitigated.

The enforcement action we took:

We served the provider and registered manager a warning notice and asked them to meet the regulation by 21 July 2017.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure that systems were established and operated effectively to ensure compliance with the regulations. The systems and procedures in place to assess, monitor and drive improvement in the quality and safety of people were not effective. The provider had failed to ensure that people were protected against the risks of unsafe or inappropriate care arising from a lack of proper accurate records.

The enforcement action we took:

We served the provider and registered manager a warning notice and asked them to meet the regulation by 21 July 2017.