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Care Assistance

Inspection report

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Tel: 01709543361

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place over the period of 14 February 2018 to 26 February 2018, with the registered provider being given short notice of the visit to the office in line with our current methodology for inspecting domiciliary care agencies. The service was last inspected in July 2017, and was given an overall rating of "requires improvement." Five breaches of regulations were identified at that inspection, relating to; how the service was managed and the governance arrangements; how medicines were managed; how consent was obtained and acted upon; a failure to notify the Care Quality Commission (CQC) of specific incidents where required; and a failure to display their CQC rating.

At our inspection of 14 February 2018 to 26 February 2018 we found the registered provider had failed to act on the findings of the previous inspection and address all the breaches of regulation identified at that inspection.

Care Assistance is a domiciliary care agency. It provides personal care to people living in their own houses and flats and specialist housing. It provides a service to older adults and younger disabled adults. At the time of the inspection the registered provider could not tell us precisely how many people they were providing personal care to, but told us they thought it was "about 80."

The provider was registered as an individual, meaning that there was no requirement for a registered manager.

People using the service told us they found staff to be caring, telling us they had a good relationship with the staff who provided care for them. However, they told us that at times care calls could be late. A small number of people told us there had been missed care calls in the past.

People's medicines were not appropriately managed, with staff at times administering medicines that were not supported by records. Risk assessments lacked detail and did not give sufficient information about how staff should act in order to manage and minimise risks.

The registered provider did not have appropriate arrangements to ensure they complied with the Mental Capacity Act 2005 (MCA.) People's consent was not always lawfully obtained, and where people lacked the mental capacity to give consent to their care, the correct steps were not followed.

The registered provider had a complaints policy in place, but did not follow this policy when addressing complaints.We saw incidents of complaints not being appropriately investigated or responded to.

The registered provider was failing to carry out sufficiently robust audits to ensure that shortfalls or concerns were identified and addressed. The registered provider did not have a system in place to monitor the quality of service provided, and could not evidence that it was complying with the law in this area.

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.

You can see what action we told the provider to take at the back of the full version of the report. We are taking enforcement action against the provider, and will report on this at a later date.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There was a safeguarding policy and clear procedures for staff to follow if they suspected abuse. Most staff had received training in relation to this. However, we found that the registered provider had not followed correct procedures when dealing with allegations of abuse.

Medicines were not managed safely; records were not fit for purpose, and staff were not administering medication in accordance with people's assessed needs.

Recruitment was carried out safely, although we noted that suitable references were not always obtained for staff.

Is the service effective?

Inadequate

The service was not effective.

The registered provider had not followed the correct, legally required, procedures when obtaining people's consent to their care and treatment. Where people lacked the capacity to give consent, the registered provider was unaware of the steps they were required to take.

Staff told us they felt well trained to do their jobs, although we noted there were some key areas of training that staff had not received.

People's nutritional needs were not always met, and we received some negative feedback from people using the service and their relatives about the quality of meals they were provided with.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us they had good relationships with the staff providing their care, however they told us about times that care calls had been missed or staff had arrived late. They told us that staff often seemed hurried, and staff we spoke with confirmed

this.

Records showed that there was a lack of detail about the care people required or the care that people were receiving.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was little evidence that people's care was formally reviewed to ensure that it continued to meet their needs. The registered provider told us they were in frequent contact with people using the service, but acknowledged that they did not have a formal review system.

Complaints were not appropriately managed.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not have a system in place for monitoring, assessing or improving the quality of service provided, and di not have an adequate understanding of how to implement such a system or the requirement to do so. The provider had failed to act upon the findings of previous inspections in order to address shortfalls in the service.

The provider failed to make certain, legally required, notifications to the Care Quality Commission.

Care Assistance

Detailed findings

Background to this inspection

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

We gave the service 48 hours' notice of the inspection visit because the registered provider is often out of the office supporting staff or providing care. We needed to be sure that they would be in. Inspection site visit activity started on 14 February 2018 and ended on 26 February 2018. It included visiting people using the service in their own homes and speaking with staff and people using the service by telephone. We visited the office location on 14 February 2018 to see the registered provider and office staff and to review care records and policies and procedures. The inspection was undertaken by two adult social care inspectors.

To help us to plan and identify areas to focus on in the inspection we considered all the information we held about the service, including information gained from people using the service and their relatives who had contacted CQC to share feedback about the service. We contacted one of the organisations who commissioned the service to seek their views about the service provided.

Prior to inspection we had been made aware of concerns raised by the local authority in relation to some aspects of service delivery. In response to this the local authority had placed the service under an embargo, which means that they would not be placing any new service users with Care Assistance for a fixed period until improvements had been made.

During the inspection site visit we looked at documentation including care records, risk assessments, personnel and training files and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

When we inspected the service in July 2017, we found shortfalls in the way that the registered provider ensured people's safety. We rated the service Requires Improvement for the domain of safe.

At this inspection, we asked people using the service and their relatives whether they felt safe when receiving care from Care Assistance. One said: "I have no problems in that respect," although another told us: "I don't trust them." Staff we spoke with had a good knowledge of the steps they needed to take to ensure people were cared for safely, although one said: "I don't always have time on calls."

We checked to see whether care and support was planned and delivered in a way that ensured people's safety and welfare. We looked at eight people's care plans which all contained brief assessments to identify and monitor any specific areas where people were more at risk, such as how to move them safely. However, these were completed in a tick box style and did not contain any specific information about what steps staff should take to ensure people were safe when being cared for.

In addition to these tick box style risk assessments, there were further moving and handling risk assessments which were completed where people required specific assistance in this area. We noted, however, that in one case this had not been completed at the intended frequency, meaning that it was unclear whether the risk assessment was still suitable to the person's needs. One person's daily notes, where staff record details of the care given, indicated that the person could present behaviour which was a risk to staff. This person's file did not contain any kind of risk assessment or care plan. The registered provider forwarded a care plan and risk assessment relating to this person after the inspection. It described person's behaviours but did not describe any management strategies that staff should employ to minimise the risk of harm. This put both the staff as well as the person them self at risk of harm.

We looked at how care plans reflected the risks associated with people's care. One person's file contained an assessment from a speech and language therapist stating that the person was at risk of choking when eating and drinking. They advised that the person should be given drinks with thickeners in, and follow a diet of appropriate foodstuffs. There was no reference to this in the person's care plan, and their daily notes did not indicate that staff were adhering to this guidance. Another person's care plan reflected that they were extremely underweight and at risk of malnutrition. There was again no further information in their care plan setting out what steps staff should take to manage this risk.

We looked at how the registered provider responded to "contract concerns" involving safety-related incidents. Contract concerns are raised by the local authority when they have become aware of concerning information, and require providers to investigate and respond. In response to one of these the registered provider had responded: "It's impossible to resolve." Another one included an incident where care staff had given a person their medication at the wrong time of day, which put the person at risk of being drowsy during the day and could have had a negative impact on their mobility. The registered provider did not respond to this aspect of the concern. We asked to see the notes from the registered provider's investigations into these incidents. They told us that they did not keep records of such. This meant that the

provider was not taking sufficient steps to ensure people's safety.

We looked at the way medicines were managed by the registered provider. In some cases staff were required to prompt people to take their medication, and in others staff were required to administer it. This was set out in each person's care plan, along with details of each person's medication. However, when we checked people's daily notes we found that staff were not always providing medication support in the way that people had been assessed as requiring. For example, one person's care plan stated that staff should prompt them to take their medication, but in the daily notes staff were recording that they had instead administered it. Another person's notes indicated that staff had applied a medicated cream to a person when there were no details in their care plan stating that staff should do this. A third person's care plan showed that they had been prescribed a medicine to be administered on an "as and when" basis, often referred to as PRN. Their file contained no information about under what circumstances staff should administer this, what the desired outcome was, and what action staff should take if the desired outcome was not achieved.

We asked the registered provider how they monitored the way that medicines were managed. They told us that they read people's files and check the medication administration records (MARs). However, none of the people's MARs we asked to see were available in the office. The registered provider told us that staff were "meant to bring them [the MARs] in to the office, but sometimes they don't." There were also no records available evidencing that the registered provider had audited the way medication was managed in the service. This meant that the registered provider did not have appropriate arrangements in place to ensure medicines were managed safely.

We checked staff training records to check whether staff had received an appropriate level of training to ensure people were cared for safely. We found that whilst most staff had received training in safeguarding, the provider's own training records indicated that a large number of staff had received training in key areas such as infection control, food hygiene, health and safety, and fire awareness. This meant there was a risk of people coming to harm due to staff not having sufficient training.

This is a continued breach of regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

We checked how the registered provider managed safeguarding within the service. They told us that all staff had received safeguarding training, and each staff file we checked confirmed this. The local authority had alerted CQC to a number of incidents within the service where a person using the service had been subject to suspected abuse, predominantly by way of neglect due to missed care calls. The registered provider had not notified CQC about any of these incidents, which is a legal requirement. The registered provider told us about incidents they were aware of where vulnerable adults may have suffered abuse perpetrated by other organisations. The registered provider told us they had not alerted the appropriate authorities because to do so "doesn't seem right, not when it's [large provider of services.]" We discussed other recent incidents that had happened within the service. The registered provider had not alerted the local authority safeguarding team and had not recognised the requirement to do so. This meant that the registered provider was failing to take appropriate steps to protect people from the risk of abuse.

This is a breach of regulation 13 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014

We looked at a sample of five staff files, to check whether recruitment was carried out safely. All staff underwent a Disclosure and Barring Service (DBS) check before starting work. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and

vulnerable adults, to help employers make safer recruitment decisions. Where staff had previously worked with vulnerable adults, their reason for leaving had been recorded, and the registered provider sought two references for each prospective employee. We noted, however, that in some cases the references weren't appropriate. One staff member's references were from a friend and a relative rather than their previous employer. Another staff member's references were both personal, despite them being previously employed by a large commercial organisation. The registered provider told us that this staff member's reference from their previous employer was "on the computer" but did not present it to us.

Inadequate

Is the service effective?

Our findings

When we inspected this service in 2017, we found the registered provider was not complying with key legislation around consent. We told the registered provider they must address this, and rated them as Requires Improvement for this domain.

At this inspection in February 2018, we found that the registered provider had failed to address this. We checked eight people's care plans to see how the registered provider ensured that care was provided in accordance with people's expressed consent. We found that the registered provider used a form for people to give consent to their care, however, it was always used in a way which complies with the law. For example, we found some forms had been signed by people's relatives. Where people have the mental capacity to give consent to their care and treatment, another person can only consent on their behalf if they have been appointed to do so by the Court of Protection. This is called a Lasting Power of Attorney. The registered provider told us that in one case they believed the relative did have lasting power of attorney, but they had no paperwork to support this. They told us the relative showed them "a form" but they did not take a copy of it. The registered provider had not requested confirmation from the Court of Protection, and therefore could not be reassured they were acting lawfully. Another person's file contained a blank consent form, which had a note on it stating it was awaiting a relative's signature. Again there was no information in this person's file indicating that the relative held Lasting Power of Attorney.

We requested to see the care plan of a person who lacked capacity to give consent to their care and support. The registered provider told us that the person concerned lacked mental capacity but there was no information in their care plan to support this, such as an assessment of the person's mental capacity. Where people lack capacity, decisions that are made on their behalf should be made in the person's best interests, and people who know the person well should be consulted for their views about the decision. We found that the registered provider could not evidence that they had done this.

We asked the member of staff responsible for devising care plans how they would gain consent to care and treatment where a person lacks capacity. They told us they would obtain consent from the person's next of kin. They were not familiar with best interest decision making or the processes set out in the Mental Capacity Act (2005) Code of Practice. The registered provider's training records showed that few staff had received training in relation to mental capacity. This meant there was an ongoing risk that people's care may be provided in a way that didn't reflect lawful practice.

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

We looked at how the registered provider ensured people received good nutrition and hydration. Several of the care plans we checked showed that staff were responsible for meal preparation and ensuring that people ate. However, according to the registered provider's own training records very few staff had received training in food hygiene. One relative told us that care staff were responsible for buying food for their relative, but they often bought food that their relative didn't like. They also told us that care staff often left

the kitchen untidy. One person using the service told us that the care staff couldn't cook, saying to us: "How difficult is it to boil an egg? They haven't got a clue."

One person's care plan showed that they were extremely underweight, and their assessment stated that they were at risk of malnutrition. However, there was no risk assessment relating to this. Staff were responsible for preparing this person's food but they were not recording what was being provided or how much the person was eating.

We looked at the procedures in place to ensure that the registered provider was aware of people's cultural needs and ensured that they protected people from discrimination. We found that in most care plans there was very little information about people's cultural beliefs or needs, and often the initial care assessment recorded this as "not discussed" although we did note that most staff had received training in equality and diversity. We noted that an investigation into a complaint carried out by a senior staff member recorded: "As [the person] is a private customer it is important he….is getting the care he needs and the time he is paying for." It was concerning that a senior staff member considered that a person who was funding their own care should be distinct from a person whose care was paid for by the local authority, and this discriminatory approach had not been identified by the registered provider.

Requires Improvement

Is the service caring?

Our findings

When we inspected the service in July 2017 we rated them "good" for this domain. However, at the inspection of February 2018 we found it had deteriorated to "requires improvement."

People we spoke with predominantly told us they found the staff to be caring, although some commented on the lack of time staff seemed to have. One person told us the service was "fabulous" and described the care workers as "first rate." They told us they had no complaints about the service provided. Another person was very complimentary about the care they received and the way staff supported them. They told us: "We can't fault them [staff]. They are occasionally late, but it's not enough to complain about." They could not remember any missed care calls but said: "I worry when they don't come on time." They said they received a "good service." They said they had a few different care workers but described them all as "lovely."

On the other hand, some of the people we spoke with raised concerns about the time staff were allocated. One said: "They have to rush because they are run off their feet." A relative of a person using the service told us: "They never give [my relative] choice. They never ask what [the person] wants to eat, they just make a sandwich of their own choosing and plonk it down." They described that the care staff had "taken choice away" from their relative.

We checked a sample of eight care plans to see whether there was evidence that people receiving care at the time of the inspection had been involved in making decisions about their care, and contributed their opinions to the way their care was delivered. We found little evidence their views had been sought, although people we spoke with told us they were familiar with the contents of their care plans.

Each care plan we checked set out how people's care should be provided, although this was in limited detail and did not always describe the care that staff were providing. For example, one person had a catheter but there was no information in their care plan about any actions staff needed to take in relation to this. The registered provider told us that this was because the person's relative dealt with this aspect of their care needs. However, the person's daily notes, where staff record the care provided, showed that staff were in fact providing some support in this area. We raised this with the registered provider and they told us that this was minimal, failing to recognise that staff should only be providing care in the way that the person has been assessed as requiring.

We looked at whether people were receiving care calls for the duration that they had been assessed as requiring. We found that records showed calls were at times shorter than people's assessments set out. We raised this with the registered provider. They told us that on many occasions staff stay for longer than the assessed requirement, although we saw no evidence of this in the care records we looked at.

We looked at feedback that people using the service and their relatives had given to the registered provider. The majority of feedback was positive, with one person saying: "Always there when I need them, all carers are close to me." Another said: "[The care staff are] usually bang on time, and always cheerful." However, some made reference to missed care calls or irregular times, and one said: "Some [care staff] don't know

how to cook or clean up." A relative we spoke with echoed this telling us they were concerned that care staff often did not tidy up after themselves. One relative told us: "The staff leave used tea bags on the floor by the bin, and spillages on the kitchen sides. The staff are the only people who go in the kitchen so it must be them."

The care plans we checked showed little reference to people's dignity or privacy, although we noted that most staff had received training in this area. Staff we spoke with told us they tried hard to uphold people's dignity and provide person centred care, but told us it was sometimes difficult. Every staff member we spoke with told us they had to rush care calls at times because they hadn't been scheduled enough time to get from one visit to another. One staff member told us about the app the registered provider used to send them details of their care calls, and said: "I just wish we had some detail about clients, the app will pop up today telling me I'm going to X tomorrow and I don't know him, the app says toilet, wash, prep meal but that's it, I don't know if it's prompting or fully doing, I don't know what food they like and if he's not got capacity, I can't find out. I don't know where I'm going tomorrow anyway until the app updates this evening" They told us that they felt they were compromising people's independence if they didn't know what the person could do for themselves.

This is a breach of regulation 9 of the Health and Social Care Act (2008) (Regulated Activities) Regulations (2014

Requires Improvement

Is the service responsive?

Our findings

When we inspected the service in July 2017 we rated them "good" for this domain. However, at the inspection of February 2018 we found it had deteriorated to "requires improvement."

We checked eight people's care records to check whether they appropriately supported good care. We found that they were lacking in detail and, in some places, inaccurate. One person's care plan stated that they used a specific piece of equipment to assist with mobility, however, there was no corresponding risk assessment. The registered provider told us this person didn't use that equipment and therefore no risk assessment was required. We asked the registered provider if this meant the care plan was inaccurate, and they replied "it must be."

The registered provider told us that they had recently employed a member of staff to re-write everyone's care plans. We asked this staff member what training they had received in relation to care planning, but they told us that had not had any. It was not clear, therefore, why the registered provider considered that an untrained person would be an appropriate person to develop care plans.

We looked at how the registered provider used technology to manage people's care calls. They had invested in a system which scheduled care calls and communicated care rotas to staff by means of a mobile phone app. The registered provider acknowledged, however, that some staff did not check their app, which had resulted in missed care calls. During the inspection a relative phoned the office to ask where their care worker was as they had requested an early care call so that the person using the service could undertake a social activity. The registered provider spoke with the staff member concerned and ascertained that they had not checked their app, meaning that the person did not get their care visit at the time they had requested. There had been similar incidents reported to the local authority, where care visits had not taken place due to staff failing to use the app correctly, or on one occasion where the scheduling system had allocated care visits to a staff member who was not working. The registered provider was in the process of installing technology in each person's home which they told us would enable them to better monitor care visits.

We noted that in some care records visits recorded were shorter in length than the intended time period. The registered provider told us this could be due to the person telling care staff that they did not want them to stay any longer as all their needs had been met. This was not recorded in any of the records we sampled. Other records showed that people received their care visit considerably later than the time they had been told it would happen. One relative told CQC their relative received several care calls per day but told us that the registered provider will not give them set times. They told us they could not understand why this was, as in their experience all other care companies provide set times. They told us that sometimes there were missed care calls and recently a lunchtime call had not taken place by 2.45pm. The registered provider did not have a system of auditing whether calls were attended on time and therefore could not identify trends or concerns.

We checked the arrangements in place for formal reviews of people's care. There were no records to

evidence that this was happening. The registered provider told us that they are in "constant contact" with people using the service and their relatives, and would therefore make any adjustments that were required. We asked if they had a system for formally reviewing care, but they told us they did not.

We looked at how the provider managed complaints. The registered provider had a complaints policy which was given to people using the service as part of their service user guide, however, it did not contain accurate information. We had advised the registered provider about this at the last inspection but they had failed to address it. The registered provider had received four complaints in the period since the last inspection. We looked at records of these and found that none of the complainants had received a written response from the provider, despite it being their policy that they did so. We asked the registered provider about this. They told us that in relation to complaints "we just have a chat and sort it out."

Two of the complaints concerned a member of staff and the actions and attitude of this staff member. There was evidence within the complaints records that the staff member concerned had been given sight of the two complaints against them. This meant that the registered provider had failed to uphold the confidentiality of the complainants. We asked to see records of investigations the registered provider had undertaken in relation to each complaint but they said that they didn't keep such records. This, along with the lack of written responses, meant there was little evidence that each complaint had been appropriately investigated.

This is 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

When we inspected the service in July 2017, we identified concerns in relation to leadership and governance. We rated the service "inadequate" for this domain. We judged that the registered provider was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 in addition to breaches of other regulations. We wrote to the registered provider and told them that they must send CQC an action plan setting out what they were going to do to address the breaches of regulations we identified. They failed to respond to this instruction.

At our inspection of July 2017, we also gave the registered provider written feedback setting out the areas where there were breaches and shortfalls in service provision. At this inspection, we found that he provider had failed to address the vast majority of concerns set out in both the written feedback and in the report of the July 2017 inspection.

We looked at records of various incidents and occurrences that had taken place within the service over the preceding months. We identified that, where these incidents had been notifiable, by law, to CQC, the registered provider had failed to do so. We had raised this during the 2017 inspection, and the registered provider gave us reassurances that they would address this matter. We found that they had not done so, and told us that they hadn't been aware that these incidents were notifiable, despite being told this was the case in the previous inspection. We are considering our enforcement options in relation to the provider's failure to notify.

At the inspection of 2017, we identified that the registered provider had no systems in place to monitor the quality of the service. We told the registered provider that they must address this, so that they had an oversight of the care provided and they could assess, monitor and improve the service provided. At this inspection, we found the registered provider had failed to do this. We asked to look at audit documentation. We were shown a spreadsheet on which the registered provider had recorded the dates of staff supervision. There was no analysis of the quality or effectiveness of supervision, and not action plans to improve it. We explained to the registered provider that a list of dates did not constitute an audit, to which they asked: "What's an audit?" This gave cause for concern about the knowledge and skills of the registered provider.

We asked the registered provider how they monitored the quality of care documentation and care delivery. They told us they did this by way of a system of spot checks. We checked the documentation accompanying spot checks, but found it was lacking. It included a check of care plans, but each one we saw recorded that care plans were fit for purpose. We found that, when we checked care plans, none of the ones we checked was fit for purpose. This meant that the registered provider was failing to recognise shortfalls in the way they managed the service.

Many of the daily notes we checked, which are where staff recorded the details of the care they had provided, contained concerning information, such as staff administering medication inappropriately, or care visits falling considerably short of the duration the person had been assessed as requiring. We asked the registered provider how they monitored daily notes. They told us: "I just read them." We asked the registered

provider if they carried out an audit of daily notes, and they replied: "I suppose I don't." This approach had failed to identify any of the concerning information we had seen. This meant that the registered provider did not have an adequate system in place to monitor or improve the quality of the care provided, or address any shortfalls.

In many of the care plans we looked at, we found contradictory, missing or inaccurate information. We asked the registered provider how they audited care plans. They told us they did this by reading them. We asked if they had a system in place for checking the accuracy and suitability of care plans and risk assessments. Again they told us that they read them. We pointed out some of the inaccurate, contradictory and missing information, and they acknowledged that they must have missed this.

This is a continued breach of regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

We looked at the arrangements in place for improving the service and learning from incidents and untoward events. The registered provider told us that they didn't have any kind of documentary evidence to show that they were doing this, but said that they were always thinking about how to improve the service. They told us that they were considering appointing someone to become registered manager. The provider is registered with CQC as an individual rather than as a company or partnership. This means that the registered provider does not have a registered manager. The provider was unaware of this, indicating that they did not have an understanding of the CQC requirements of their registration.

The registered provider's policy for carrying out formal staff supervision was that it should take place four times a year. We checked a sample of five staff files, but found that it was not taking place at this frequency. The registered provider supplied us with a list of dates when they said staff had received supervision, but this did not correlate with the records in the staff files we checked. The registered provider told us they have other, informal, chats with staff, but that they did not document this.

We asked staff about the leadership and governance of the service. One told us: "It's so disorganised, I'm looking for another job." They told us that they didn't know what care visits they were going on the next day as the app, which allocates their work schedules, was updated on a daily basis. Another said: "She [the registered provider] tries but she doesn't know what's going on." We spoke with two people's relatives about the leadership of the service. One told us that management were accessible, although the other relative told us this was not their experience. They both told us they found the service to be poorly organised, with one saying: "There is a lack of organisation."

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 registered provider did not take steps to ensure that people using the service received care that met their needs.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider did not take steps to ensure that consent was lawfully obtained and acted upon, and did not have appropriate arrangements in place where people lacked the capacity to give consent. Regulation 11(1)(2)(3)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider was failing to ensure the safety of people using the service. Risks were not appropriately assessed and managed. Medicines were not managed safely and staff did not have an adequate level of training in relation to the provision of safe care. Regulation 12(1)(2)(a)(b)(c)(g)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider did not have sufficient

processes or systems to protect people using the service from the risk of abuse. Regulation 13(1)(2)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered provider did not have adequate systems in place to identify, record, and investigate complaints. Regulation 16(1)(2)

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 17 HSCA RA Regulations 2014 Good governance The registered provider did not have adequate systems in place to assess, monitor or improve the quality and safety of the service provided. Regulation 17(1)(2)(a)(b)(f)

The enforcement action we took:

Warning Notice