Fortress Supported Living Services Ltd

Fortress Care Services

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was unannounced on 9 and 23 August but was announced on 17 and 25 August 2017.

Fortress Care services is a service that provides personal care to people in their own homes. At the time of the inspection nine people were receiving support from the service.

There was a registered manager in place. They were also the owner and director of the business. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. At the time of our inspection the registered manager was on long term leave and we did not speak with them. The business was being run by their partner, who was also the owner and nominated individual of the business, which meant they had a legal responsibility for the service.

At our last inspection on 23 April 2015 we rated the service as Good. This scheduled inspection was arranged to assess the quality of care currently being delivered and to address some concerns which had been raised with us.

At this inspection we had serious concerns about the quality and safety of the service.

The service failed to provide consistently safe care. People were not protected from the risk of abuse as the provider failed to operate a robust recruitment procedure. Required checks to make sure staff were safe and legal to work at the service had not been carried out thoroughly. Staff, who were the subject of a current safeguarding investigation were working unsupervised without the risk being assessed and action taken to mitigate it.

Accidents and incidents were not well managed and the provider failed to notify the appropriate authorities or to carry out investigations when people's safety had been placed at risk.

There was no effective staffing strategy in place to cover emergencies and staff annual leave. This meant that people received inconsistent care or did not receive the care they needed.

Medicines were managed safely and people received their medicines according to the prescriber's instructions.

Staff training, including medicines training, was in place but the provider could not supply accurate records to confirm when staff had received their training. Staff had not had some specific training, such as training for particular health conditions.

Records did not demonstrate that people had consented to their care. The service was not operating in line

with the Mental Capacity Act 2005 (MCA).The MCA ensures that people's capacity to consent to care and treatment is assessed. If people do not have the capacity to consent for themselves the appropriate professionals, relatives or legal representatives should be involved to ensure that decisions are taken in people's best interests according to a structured process.

People were supported with their eating and drinking and were positive about this aspect of their care. Healthcare needs were mostly met but records for some people, who had 24 hour live-in care packages, did not show that their health needs were well monitored by other health professionals such as dentists and opticians.

Staff were mostly very caring and held in very high regard by people who used the service. People felt their dignity and privacy was maintained. Feedback about some staff's disrespectful language and behaviour was negative.

People did not receive care which reflected their individual needs and preferences. Some care was delivered according to the availability of staff rather than the preferences of the person who used the service.

People were not clear about how they should make a complaint. Some people who used the service, and their relatives, had significant and serious complaints and we were not clear why they had not felt able to raise these with the provider.

Ultimately the service was not well-led. Despite some good and committed staff we found that people did not always receive safe and timely care which met their needs and was delivered according to their preferences. The lack of an effective staffing strategy meant that annual leave was not always covered by staff who knew people's needs well. Some care visits were missed which meant one person had to find alternative care arrangements for a period of three days.

The provider was not honest, open and transparent during the inspection process. They failed to supply us with information we requested and did not tell us the most basic information, such as how many people used the service. This meant it was difficult for us to accurately assess the service and the impact it had on people.

The provider's poor recruitment procedures and disregard for safeguarding procedures placed people at risk. On safeguarding matters the provider prioritised staff needs over those of the people who used the service.

Governance systems did not ensure that the provider had oversight of the issues affecting the service or of forward planning. This placed people at risk.

We identified several breaches of regulation during this inspection.

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

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not fully protected from the potential risk of abuse as recruitment procedures were not robust and risk assessments related to staffing were not in place. This placed people at risk of harm.

There were not enough staff to meet people's needs promptly and no strategy with regard to covering staff leave.

Risks to some people's safety were not managed effectively. Incidents or accidents were not appropriately reported or investigated.

Medicines were managed safely but information to guide and inform staff could be improved.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff induction, training and supervision needed to be improved to ensure staff were sufficiently skilled to meet people's needs.

Consent was not always obtained from people in line with the relevant legislation.

People were supported to eat and drink enough to meet their needs and to maintain their health, although staff would benefit from further training into specific health conditions.

Is the service caring?

Requires Improvement

The service was not always caring.

The staff were mostly kind and caring however, negative feedback was received about some staff.

People were able to make decisions about their care but their wishes and preferences were not always respected.

People were mostly treated with dignity and respect and their privacy was maintained but some negative feedback was received about disrespectful and unkind language.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care did not always reflect people's individual needs and preferences.

People did not know how to complain and were reluctant to raise issues with the provider.

Is the service well-led?

Inadequate

The service was not well led.

The provider was not honest, open and transparent. They demonstrated poor judgement with regard to keeping people safe.

The lack of an effective staffing strategy placed people at risk.

The governance systems at the service did not ensure that the provider had good oversight of current issues and did not show evidence of forward planning.

Fortress Care Services

Detailed findings

Background to this inspection

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

This inspection was unannounced on 9 and 23 August but was announced on 17 and 25 August 2017. Visits to people who used the service were undertaken on 9 and 25 August 2017 and these were arranged by the provider. Phone calls to other people who used the service took place between 9 and 25 August 2017.

The inspection team consisted of two inspectors on 9 August, one inspector on 17 August, one inspector and an inspection manager on 23 August and one inspector carried out a visit to a person who used the service on 25 August.

Before we inspected we reviewed the information we held about the service. This included any statutory notifications that had been sent to us. A notification is information about important events which the service is required to send us by law.

We also reviewed the Provider Information Return (PIR) which the provider had completed. 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.

During this inspection, we spoke with four people who used the service, five relatives, two staff, and the owner and director of the business. We also spoke with staff from the local authority safeguarding team and to adult social care staff from two different local authorities. Following our inspection we spoke with staff from the United Kingdom Visas and Immigration Compliance and Enforcement Team.

We looked at the care records and risk assessments of all the people who used the service, 15 staff recruitment records and information relating to staff training. We also looked at records relating to the quality and safety of the service.

Inadequate

Is the service safe?

Our findings

We identified a number of serious concerns with regard to the safety of the service. We found that the provider failed to ensure that people were protected from the risk of abuse. Our most significant concern related to a member of staff who was the subject of an open safeguarding investigation. The provider was aware of this current investigation and aware of the serious nature of the allegation made against the staff member. Despite this the provider had conducted no risk assessment and had enabled the staff member to continue lone working with people who used the service. The provider told us they had made their own judgement about the allegation rather than waiting for the outcome of the local authority safeguarding investigation. This placed people at risk of harm. A further allegation was made about this member of staff during our inspection and we referred this to the local authority safeguarding team for investigation. The provider failed to ensure that effective systems were in place to protect people from the potential risk of abuse.

In addition to these concerns we identified that one staff member's Disclosure and Barring Service (DBS) check noted multiple convictions for violent offences. These offences had taken place over a number of years, with the most recent being May 2016. The provider had not undertaken any risk assessment to establish if the staff member posed any on-going risk to the people who used the service.

During our inspection we received feedback from a relative about this same staff member. They alleged that their behaviour had been over-zealous and lacked respect. The provider did not take any immediate action in response to this negative feedback.

The provider told us that they personally supervised this staff member's work but two people who used the service and one relative told us that this was not the case. This meant that the provider had not safeguarded people from the risk of harm.

Both the provider and a member of staff told us that they were concerned about a person who used the service. The felt they were at risk of neglecting themselves. The staff member had informed the provider who told us they had shared this information with the local authority. However, this was not recorded anywhere in the person's care plan and we could not be assured that action had been taken to safeguard this person.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We reviewed the provider's recruitment procedures to check if staff had been safely recruited. The provider was unable to locate the DBS check for two members of staff or their own DBS check. They did however apply to undertake a new DBS check for themselves by the time of our second inspection visit. Other aspects of the recruitment system required improvements. The provider requested two references for each staff member but we saw that often only one had been received. One person had no references on file. References were not always appropriately checked to make sure they were genuine. One member of staff's reference stated that in their previous care role they, 'could not cope with the demands of the job'. The provider had not discussed this further with the staff member and failed to identify that this might be a

matter of concern. Some staff's references were from employers other than their most recent employer. This meant the provider had not been sufficiently diligent in establishing staff member's conduct in previous employment.

The provider did not demonstrate that they had checked gaps in people's employment history or carried out effective identity checks for each staff member to ensure they had a legal right to live and work in the United Kingdom. Although the provider carried out interviews with staff, there was limited information to show how they had ensured that all staff had the required competence, skills and experience.

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

We looked at how the provider managed risk and found that risks assessments were not always comprehensive, did not contain sufficient detail to guide staff, and had not all been regularly reviewed. We saw that one person's moving and handling risk assessment had been reviewed on 11 May 2017 and reflected the person's changing needs as their condition deteriorated.

However, another person's moving and handling risk assessment had not been reviewed since 2 November 2015. They had a degenerative condition which affected their mobility. The risk assessment contained out of date information such as 'transfers to sofa with minimal support' and '[name of person who used the service] will thereafter transfer on to her wheelchair', whereas the person actually required a significant amount of support from the staff member and could not weight bear.

Guidance for staff was vague such as 'should be supported to get onto the wheeled commode'. This failed to explain exactly how staff should support this person safely. We noted that this person had fallen four times during a moving and handling procedure and sustained bruising. Staff supporting them at the time had not been their regular staff member. There was no evidence that the staff member had received any specific training or induction with regard to this person's moving and handling needs. The staff member did not report this incident to the provider at the time. The provider told us that there was a known problem with this person's moving and handling equipment but this was not recorded anywhere to alert staff. We could not be assured that all measures had been taken to alert and guide staff about possible risks.

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

We found a very confusing and mixed picture with regard to the staffing of the service. The provider kept no rotas which meant we could not review staffing over a period of time. On the first day of our inspection the provider told us they had one permanent member of staff and four people who used the service. They stated that this staff member worked seven days a week and their annual leave was covered by the registered manager or the nominated individual of the business. This staff member confirmed that they worked seven days a week and stated that this worked well and demonstrated how they were able to provide the required care for the four people in a timely way. People who used the service, and their relatives, confirmed this and gave extremely positive feedback about this staff member. One relative said, "[They are] brilliant. [They] bond with everyone in our family. [They are] absolutely brilliant". A person who used the service said, "We couldn't do without [them]. [They] take the initiative. [They] are absolutely wonderful. I cannot praise [them] enough". Another told us, "I have no problems. [They are] everything to me".

This staff member clearly delivered a reliable and high quality service to these four people. However, we found that during their recent two week annual leave period, the provider had failed to ensure that people continued to receive a safe and reliable service. One person failed to receive care visits for three days and had to rely on family. Another person said that the staff employed during this two week period were, "Not

very good. They weren't up to [the usual carer's] standards…They were in and out. [We] didn't get the full time – [the carer] left quick". Another person said, "It wasn't quite as good". They continued, "These people weren't so familiar with what I needed…They need to do better next time [the usual carer] goes away". A relative commented, "It was alright. They weren't the same. No experience. It wasn't the same. The times changed – [they] came later". They added, "We don't like it when [the usual carer] goes away".

We established that some staff provided 24 hour live-in care for people. One person gave us very positive feedback about the carer supporting them saying, "Smashing – and that's the truth". This person required a second staff member to assist them with moving and handling needs. We saw that often the second carer, who came from another agency, came at unsuitable times which meant that the Fortress Care Services staff occasionally hoisted the person on their own. The provider had not tried to address this issue which continued to place both the person and the carer at risk.

We were concerned that this person's needs and preferences were not always respected due to a lack of appropriate staffing. One record stated, '[Person] refused to go to bed because of [their] visitor'. This record was at 13.05. We saw that this person was usually in bed by 14.00 each day. Records for the days before our visit stated 'taken to bed at 13.10' and '13.15: [Person] was put in bed'. We asked the person if this was their choice and they confirmed that it was not. One record stated, 'declined the rest of meal – told [they] should have it now whilst sitting rather than in bed, so [they] ate it'. The person was then returned to bed at 15.00. This meant the person was going back to bed, for the afternoon into the evening, because appropriate staffing was not in place.

By the end of our third inspection visit we had identified that, contrary to what the provider had originally told us, there were nine people receiving a service and fifteen members of staff. We found that these staff varied in skills, competence and experience. Some staff had been taken on to provide additional cover for holidays but we found they had been expected to undertake shifts before they had received a proper induction. The staffing picture was chaotic and demonstrated that the provider did not have a clear strategy in place to ensure people always received consistent, high quality care.

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

The provider told us at first that they did not support any people who used the service with their medicines. We found this was not the case and saw that several people required support, some needing full assistance. We reviewed records related to medicines and talked to people who used the service. People told us that they received their medicines on time and staff checked if they needed extra medicines such as pain relief. Medication administration records (MAR) charts were completed with no gaps where staff had signed to confirm they had given the medicines. There was no information for staff to guide them about what each medicine was for and no information, on the records we saw, about how each person liked to take their medicines. We also noted some disrespectful language on one chart instructing staff to administer creams on a person's 'groin and bum'.

Risk assessments regarding people's medicines were varied. One we saw was very good and reflected the person's changing needs, another was blank and no record was present about the person managing their own medicines.

Some staff had certificates for medicines training and told us that this had been online training. Each staff member had a general certificate issued once a year by the provider, which confirmed medicines training had taken place. We asked to see a full list of staff training which showed exactly when staff had undertaken their medicines training, but this was not supplied. The complexity of some people's needs with regard to

their medicines, a lack of clear information and a confused staffing picture did not assure us that staff would always be able to provide safe management of medicines.

Requires Improvement

Is the service effective?

Our findings

We received mixed feedback from people who used the service, and their relatives regarding staff competence to perform their role. Some care staff were held in high regard by the people they supported and cared for while others prompted more negative feedback. One relative told us that the carer undertaking night shifts in their relative's home was, "Very good. I really can't fault [them]…Believe you me, if I had any problems I would get on the phone".

People were satisfied that their regular staff had the skills and knowledge to provide them with effective care. We noted that the provider undertook spot checks and regular supervision for some staff. Some staff had undertaken nationally recognised qualifications in care. Others had limited records and we noted that some staff had not received an appropriate induction before starting their care roles. For example one person had been employed as an administrative assistant primarily. The provider told us the intention was for them to also be a bank worker to cover annual leave, after a period of shadowing. We saw that this person had no record of any induction, no training had been provided or any supervision recorded. We identified that this person had been expected to undertake a care shift the previous week but their prior commitments had prevented them from doing so. We were not assured that the provider had satisfied themselves that this person had the required skills and knowledge to undertake this role.

Another staff member, who had not worked in the care sector before, had started work in June 2017. They had undertaken some training before they took up their employment but the nature of this training was not clear. They had been carrying out care shifts within two weeks of starting work and there were no supervision records or records of any shadowing or competency assessment of their work. Feedback about this staff member was poor from the people we spoke with.

All staff had an annual certificate which listed their training including, safeguarding, moving and handling, infection control, fire, risk reporting and food hygiene. The certificates were dated with a single date and the provider was not able to explain to us when each person had undertaken each course, even though the provider had delivered some of the training personally. This meant we could not assess the quality of this training. Staff told us that most training was online and we found some staff did not demonstrate a clear understanding of safeguarding or risk reporting. The provider had not ensured that staff had received training related to some people's complex health conditions.

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

Staff did not receive training with regard to the Mental Capacity Act 2005 (MCA), although staff we observed ensured they asked people's permission to provide them with care and support. People's capacity to consent to their care had not been recorded in all care plans we saw and it was not clear that this had taken place. Where people's capacity was recorded we found this had not always been assessed in accordance with the requirement of the MCA. For example, one person's moving and handling risk assessment had a section called 'Does the service user appear to have capacity to understand the risks?'. This had been recorded as 'not applicable'. No part of this care plan had been signed by the person, or their representative.

It was not clear from their records if the person had consented to aspects of their care.

There were no capacity assessments in any care plans that we saw. We noted that the care plan for one person, who was living with dementia and who received support with personal care and medicines, had no record of their consent to this support. We asked the provider about this and they told us that the person's relative consents. They also stated that the person had been assessed as not having capacity but this was not recorded in their care plan.

We observed that another person, who had capacity to make their own decisions, was not consulted about aspects of their care. We raised a concern about their care during our inspection and the provider rang their relative to discuss this. We asked why the provider had not rung the person themselves. We asked the provider to clarify if the person has capacity to make their own decisions. The told us, "Yes – no mental impairment". It was not clear to us why several conversations about this person's care were not conducted with them, rather than with their relative. This demonstrated to us a lack of respect and a lack of understanding of the MCA on the part of the provider.

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

People who used the service, and their relatives, were happy with the way staff supported them with their eating and drinking. Staff recorded what food and drink they provided for people. Care plans did not always contain detailed information about people's eating and drinking needs, although staff were reminded to promote choice. The provider confirmed that no person required any specialised support with their eating and drinking. We observed one staff member trialling a new kind of cup to see if one person would be able to drink independently. We observed another member of staff preparing food for later in the day for one person. They made sure the person had all they needed with regard to food and drink before they left for their next call.

Some people who used the service arranged their own healthcare while others were more dependent on staff. Some people had complex physical and mental healthcare needs. We saw that information about people's current and past healthcare conditions was not clearly recorded in their care plans. This meant that we could not be assured that staff, especially new staff, would have a complete understanding of people's healthcare needs. Where other healthcare professionals were involved in people's care, records did not always document the latest information. One person who used the service said, "I don't think [my carer] knows a lot about [my condition] but [they] try to help me". Records for people receiving 24 hour live-in care packages did not demonstrate that staff comprehensively monitored people's healthcare needs. We saw no reference to opticians, dentists or chiropodists for example.

Requires Improvement

Is the service caring?

Our findings

Staff we met with demonstrated a caring attitude towards the people they were supporting. They took time to make sure the person was comfortable. We observed some staff had good relationships with people they were supporting and people gave some positive feedback. People who used the service told us that their regular carers were kind and treated them with respect. Communication was relaxed and friendly and carers provided a reassuring presence. Feedback for some carers was particularly positive with one person who used the service saying, "[[My carer is] lovely. Treats me well and we have good banter". Another person said, "We just couldn't do with out [them]. Nothing is too much".

We received less positive feedback about some other staff, including those who recently covered one regular carer's annual leave. One relative described a carer as being, "Over the top", and found their language inappropriate. They said the staff member had told their relative, a person living with dementia, to pull themselves together. They found this unhelpful. The use of this kind of language meant we were not assured of the skills and competence of this staff member. It also demonstrated a lack of respect and of kindness. We fed this back to the provider.

We found a mixed picture with regard to how involved people were with their care. One person, who had capacity to make their own decisions, told us, "[My carer] asks me monthly if I want anything changed with my care. I have a say in my care." Other people were not always consulted about their care. We spoke with one person who was not happy with some aspects of their care. We could not see from records how the service had involved them in all decisions or asked them how they felt.

Care plans, although detailed about the principles of offering care and support, were generic. They featured the same information, in exactly the same language. This demonstrated a lack of genuine dialogue with people and their relatives.

We noted that one regular carer acted as an effective advocate for one person who used the service and demonstrated an understanding of the issues affecting them. Advocacy services were not widely used for other people, although many had excellent advocates in family members.

People told us that staff ensured that their personal care was delivered in private and staff were mindful of their dignity. People told us they were not rushed when they were being supported by their regular carer. However, they did feel that staff covering for that staff member's annual leave had not been so patient.

The staffing arrangements for one person who needed a second staff member to help them with moving and handling meant that they had to fit in with the staffing pattern rather than be in control of how and when their care was delivered. This demonstrated lack of respect for their expressed wishes and we could see no evidence of staff, or the provider, finding this unacceptable.

Requires Improvement

Is the service responsive?

Our findings

People who were supported by the same regular carer seven days a week were very happy with the care they received. They all felt that the care provided met their individual needs and preferences. This particular carer demonstrated a very good knowledge of the people they were caring for and knew their likes, dislikes and preferences. Other carers received similar positive feedback and people were confident that these care staff would provide them with consistently good quality care.

Our concern was that this picture was not maintained across the whole service and that some staff were not providing this level of care. This was partly due to the lack of strategy with regard to staffing. This meant that some people were occasionally supported by staff who did not know them well. A lack of staff induction, shadowing opportunities and poor supervision and monitoring of staff contributed to some people not receiving care according to their needs. We found basic care plans, which did not always reflect people's most current needs. This added to our concerns.

Care plans were often generic and did not always clearly record people's specific care needs. We saw the same phrases and wording used on all the care plans we reviewed. Plans contained some detailed instructions for staff to guide and prompt them but the information was not always current.

Records did not show that each person had received an in depth assessment of their needs before they started receiving a service. In some plans we saw a local authority assessment documenting the person's needs but Fortress Care Service had not conducted their own assessment, to ensure they could meet these assessed needs. Each person had a client information form and the provider confirmed this was their assessment. We noted that this sometimes contained only the most basic details relating to the person's care.

We saw that care plans stated if people were happy to receive care, including personal care, from staff whose gender was different from their own. People told us their wishes were respected but we were unable to confirm this with everyone who used the service as rotas were not available.

We were concerned that people's needs and preferences were not always respected. For example, one person often had to go back to bed after lunch as that was the only time staff were available to help them with moving and handling. They had very little social stimulation or activity. We noted that their social activities care plan stated that live-in staff would provide full support to help them access the local community. We reviewed records and saw that the only time they had been out during August was for an hour and twenty minutes to have their hair cut. They had also been out once into the garden. We asked them why they did not go out more and they replied, "I don't know. It's not fun".

Although the person was very positive about the staff member supporting them we observed that their quality of life was poor and the service was only succeeding in meeting their basic care needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014

There was a complaints policy in place. The provider told us that the service had not received any formal complaints since the last inspection. There was a lack of clarity about this as the registered manager had noted on the provider information return that two complaints had been received. The provider assured us that these related to incidents where a Fortress Care Service employee was working for another agency belonging to the provider. We were unable to make further enquiries as the registered manager was on extended leave.

We asked people who used the service, and their relatives, if they knew how to complain. People were not clear how to make a formal complaint. One person, who was not funded by the local authority, said, "If I felt I needed to complain I think I contact social services". We noted that this person had not made an informal or a formal complaint when they had been left without carers for three days. Another person had also received a poor service at times and had failed to make any complaint. They told us, "I wasn't certain how to".

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014

Inadequate

Is the service well-led?

Our findings

We identified numerous concerns with regard to the leadership and governance of this service. The service had a registered manager in place. They were also an owner and director of the business. When we carried out our inspection the registered manager's partner, also an owner and director of the business, was managing the service as the registered manager was on long term leave. The provider had failed to notify us of this leave of absence. It is a legal requirement to do this for any absence over 28 days. The registered manager had been absent for nine weeks by the time of our first inspection visit on 9 August 2017.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Registration) 2009.

We found the provider was not open, honest and transparent during the inspection process. They failed to tell us how many people used the service, firstly saying four and finally confirming a figure of nine. We asked how many staff were employed and they originally told us one was employed and this increased to a final figure of fifteen. We asked if medicines were administered to people and the provider told us they were not. However we found several people were prompted or physically assisted to take their medicines by staff.

We asked the provider for specific information to be sent to us to help us form a judgement but they did not send us all the information we requested, although some was supplied. This lack of co-operation and transparency made it difficult to reach our judgments and led us to question the culture of this service.

The provider failed to act on known risks and demonstrated a disregard for safeguarding procedures by failing to suspend a staff member who was the subject of an open safeguarding investigation. The provider told us, "I have made my own judgement. There is no risk". It was not possible to make this judgement as the investigation was not complete and no outcome meeting had been held. Similarly the provider had employed another staff member with multiple convictions without appropriately assessing the potential risk. The provider told us they chose to believe the staff member's accounts of their convictions rather than accepting the judgement of the court. This demonstrates a lack of professional judgement on the part of the provider and a disregard for people's safety.

We noted that the provider also failed to take appropriate action when we identified that a person who used the service had been dropped whilst being assisted by a staff member. The provider again took the word of the staff member and did not inform the local authority safeguarding team. They had not started to carry out a formal investigation into the matter by the time of our second inspection visit. They told us that they had met with the staff member concerned but no notes of the meeting were available to confirm this. They had not identified why the staff member had not reported this serious incident which resulted in a 999 call being placed.

We identified that a similar incident had previously taken place involving the same member of staff. A meeting had been carried out following that incident but the follow up actions outlined at the meeting had not been put in place.

We found that staff were not always safely recruited or appropriately inducted and trained. Although some received regular spot checks, not all, including new staff with no care background, had their competency checked. In one staff file we noted a blank supervision record and a blank annual appraisal record which had both been signed by a staff member. We asked why this would be the case. The provider told us that they had taken notes and these were yet to be written on the signed forms. This was poor practice and meant that we could not be assured that supervision and appraisal records were accurate and agreed by staff to be a true record.

The provider did not have an effective strategy with regard to covering staff illness or annual leave. This had impacted very poorly on people and resulted in one person failing to receive care for three days. This is unacceptable practice.

Staff told us that they felt they could ask the provider for support if they needed it but worked autonomously. One staff member said, "I only contact them if there's a problem". People who used the service were not all sure who the registered manager was but most knew the owner and director who was currently managing the business. The provider carried out quality surveys with people who used the service, and their relatives, and all we saw were very positive.

Records were not well organised and some had not been updated to reflect people's current needs. The provider was in the middle of reorganising the office but was still unable to produce some records by the time of our third visit, although some had been located. Important documents such as DBS checks and right to work information could not be produced. The provider told us on several occasions that notes had been lost or were waiting to be typed up. This made it impossible for us to make a judgement about certain incidents. For example, the provider told us that they had personally supervised a new member of staff on all care visits. A relative and two people who used the service told us this was not the case. The provider had taken no notes or made any record of these competency checks so we could not verify their statement.

Daily notes were completed for each person and returned to the office in batches after a few months. It was not evident to us that the provider had oversight of this as some issues, such as the person being required to go to bed straight after lunch, had not been noted and addressed.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Registration) 2009.

We found that despite some good individual carers and pockets of good practice, the service was not ensuring people always received high quality care. The provider failed to have sufficient oversight of the issues at the service and failed to take action to address the concerns and shortfalls we identified. This lack of oversight placed people at risk.