Essex Cares Limited

Essex Cares Mid

Inspection report

Highfields Resource Centre
Moulsham Street
Chelmsford
Essex
CM2 9AQ

Tel: 01245357601
Website: www.essexcares.org

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out this inspection by visiting the registered office for Essex Cares Mid region on the 11th of March 2016. We gave the provider 24 hours' notice that we would be visiting the office to make sure that the appropriate people were there during the visit. Between the date of the visit and 24th March 2016, we visited and telephoned people who used the service to get feedback about the service. We spoke to 11 people that used the service and three relatives.

The inspection was carried out following the receipt of concerning information related to missed and late visits, and people being left without care and support. Concerns included people's personal care needs not being met; people not receiving their medicines at the prescribed times, and in some cases people being unable to access food and drink because of the lack of support.

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.

Essex Cares provides personal care to people in their own homes. At the time of inspection, up to 190 people were using the service at Essex Cares Mid. Some of these people are vulnerable due to their age and frailty, and in some cases have specific and complex health care needs.

The service provided 're-enablement' support to people in their own homes for up to of 6 weeks. Re-enablement is a service that supports people to rebuild their confidence to cope at home following their discharge from hospital .At which point the person is 'reassessed' and leaves the service having achieved their agreed independency levels or if they required on-going support they may be transferred to an alternative provider. However if suitable alternative care provision cannot be sourced the person will stay with the service under their other contract 'Resource of last resort'. This was an additional contract, which

required the service to take care packages for people where the Local authority had been unable to secure the required care provision.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Although people told us they found the staff who delivered their care to be respectful and kind, many people had experienced both late and missed visits which had led to some people missing their prescribed medication and impacting on their health and wellbeing

We looked at 15 care files and found that people's needs had not always been assessed prior to receiving a service from Essex Cares Mid. Care plans and risk assessments were incomplete and did not always ensure people's individual needs, preferences and choices were considered.

We checked how the service followed the principles of the Mental Capacity Act 2005 (MCA). The MCA governs decision-making on behalf of adults who may not be able to make particular decisions. The requirements of the MCA were not being followed. The provider failed to protect and support people safely due to ineffective and incomplete recruitment practices and insufficient staffing levels to ensure people's health and welfare was met. Staff did not always receive regular support and supervision from their managers. Staff told us they had reported significant difficulties in carrying out care; however, no actions were taken following concerns.

The provider failed to support and supervise people safely and effectively to take their medicines. Not all staff had received up to date training or supervision of their practice in relation to administering medicines or had their competency assessed.

The provider had a procedure for handling complaints, comments, and concerns but failed to ensure that complaints were handled effectively and in a timely manner. People and their relatives told us that most staff were caring and staff we spoke with had a good understanding of abuse and how to raise any concerns.

There were safeguarding policies and procedures in place. However, these were not being implemented and some safeguarding concerns were not recognised or addressed.

The provider had ineffective management and quality monitoring systems in place that failed to identify serious errors and omissions in the monitoring of missed calls, which placed people at risk of serious harm.

You can see what action we told the provider to take at the back of the full version of the report.

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 always told when carers would be late. There had been a high rate of missed calls.

People were not supported to ensure their needs were met safely.

People's medicines were not managed safely.

People did not receive their care and support as planned, as staff were not effectively deployed to provide the care.

Is the service effective?

Inadequate

The service was not effective.

Staff did not receive training relevant to their roles and did not have their competency assessed.

People had not always been supported to eat and drink sufficient amounts to help them maintain a healthy balanced diet.

People were not supported to make choices about their care and the provider did not always respect people's preferences.

Is the service caring?

Requires Improvement

The service was not consistently caring

Staff were not always respectful of people's privacy and dignity.

People were not encouraged to make decisions about their care and support.

People were not encouraged to express their views about the service that was provided to them.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs were not always met in line with their individual care plans and assessed needs.

People's care plans did not reflect current information to guide staff on the most appropriate care people required to meet their needs.

Complaints were not adequately recorded, investigated or responded to

Is the service well-led?

Inadequate

The service was not well led.

There was a manager in post; however, they had poor oversight of the service as staffing rota's were managed at a central hub.

There was a lack of communication between people, the management team and care staff.

The systems in place to monitor, identify and manage the quality of the service were inadequate

Essex Cares Mid

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 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This visit to the office took place on 10 March. Between the 14th of March and the 24th of March 2015, we visited and spoke to people receiving care from Essex Cares Mid.

We gave the provider 24 hours- notice of our intended inspection to ensure appropriate senior staff would be there to support us with the inspection. Three inspectors visited the service on the 10th of March. Before our inspection, we reviewed information we held about the service including statutory notifications relating to the service. Statutory notifications include information about important events, which the provider is required to send us.

As part of the inspection, we spoke with 14 people who used the service, nine members of staff, one manager, one director, and the head of quality and corporate governance.

We viewed people's support plans. We looked at staff recruitment records. We reviewed safeguarding records, comments and complaints records. We looked at quality monitoring records including staff support documents including individual training and supervision records. We also reviewed records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People did not always receive safe and appropriate care that met their individual needs. We saw in one person's daily notes that they had fallen and the staff member told us that they regularly found the person on their knees. However, the falls risk paperwork in their folder was blank. We witnessed a scrap piece of paper in the front of the folder to inform staff to remember to give the person their frame. One person told us, "Because they can come really late, sometime my morning call is nearly lunch time, I have to go to the toilet without help, and I am unsteady on my feet and at risk of falling."

The service recruited staff appropriately. Staff were employed to the service through values based interviews that looked at the needs of the people using the service. Staff undertook a week of mandatory training and shadowed an experienced member of staff for a further four weeks before working independently. The service did ensure that people employed had appropriate criminal records checks (DBS), and two satisfactory references before working independently.

There were not always sufficient staff members available to meet people's needs safely. This had resulted in missed and late visits. We saw that visits were sometimes not covered and these were recorded either as late or missed visits. We saw that the impact of these missed visits put people at risk. For example on occasions, people had not received assistance with taking their medicines, personal care tasks or provided with food and drink. The management team told us how the contract was structured and that a central point was used to assign work; they told us that these factors exacerbated issues and made it difficult to take corrective action. Many of the missed visits only became known following the event.

People told us that they often did not know who was coming to carry out their visits and that some visits were missed or late. One person said, "I never know when they will come." A member of staff told us they were still giving breakfast calls and morning personal care at midday. During visits with staff, we saw that they were still attending to people's breakfast and personal care needs at 11:30am. Some people needed help to go to the toilet and this meant they would have to wait for considerable time. Staff told us it was normal for them to be carrying out morning care at lunchtime, "My rota's are constantly been added to without checking I can do it." People told us how missed calls affected them and their wider family. One person told us, "We can't trust that they will be here to give [Person] their meal so we have to come and do it." Another person told us how the lack of timely visits had affected their health as "I need to take my medication with food, but visits are late and sometimes missed and this left me feeling ill. I don't eat much for the rest of the day."

The service did not safely risk assess the needs of people requiring a visit, or safely audit when missed calls had occurred and how they had affected people. The service told us that they had not had any missed calls since December. However, we found evidence of missed visits in care files that had not been recorded on the missed visits record. We saw records stating that people were contacted to ask them if they needed a visit due to short staffing. These figures were not documented as missed calls. One person said, "Sometimes they phone and ask if they are needed and I know they are busy and stressed so I don't like to make it harder for them and say no, even when I probably still need the visit."

All people we spoke to had experienced similar situations. One person said; "I can't fault the staff, they have a horrendous time. Sometimes their rotas change or they get a phone when they are in the middle of looking after me and then they have to phone whilst at mine to tell the business centre they can't take any more people on, but they are not listened too." Other people told us; "They have to shorten my time to get to the next person." The management team told us that they had 'contingency plans' and utilised all available resources but once they had utilised all their resources they could not always 'cover' some of the remaining visits and these were 'missed' visits.

We looked at the Medicine Administration Records (MAR) for five people and saw there were many gaps in the recording of medicines. We could not tell from the MAR chart whether the medicines had been given to the person or not on certain days. The missed visit record also recorded 11 occasions where medication had not been administered. We observed a member of staff trying to administer medications to a person. They had told us they struggled to understand the charts and we saw that MAR charts were confusing and disordered. Staff told us MAR charts did not always contain the right information. For example, the MARS chart had not previously identified a controlled drug. A controlled drug is a medicine controlled under the Misuse of Drugs legislation. The service policy is that two members of staff should administer these. As it had not been documented, the staff member had given it without observation.

We saw records where a member of staff had phoned the office because a person had a new box of antibiotic's that had not been recorded in the MAR Sheet. The person was written up for different antibiotics, but staff were advised to give the new antibiotic without checking with the GP. We were told that courses of antibiotics were often not taken or completed due to missed and erratic calls. One person told us; "I need to eat with my medication otherwise I can become unwell but my calls were so late that it would often mean I had to miss my medication as it would be too close to the next dose."

The service had a coordinator who managed the agency staff who had been block booked to cover rota's. The coordinator supervised and managed bank staff. However, during the inspection there had been a number of concerns raised about the quality of the service received from three agency workers, which had resulted in the service dismissing them. People using the service had made comments that whilst some agency staff were very good, others did not seem to care. "I felt like I was just a job. Get in and get out attitude." Whilst the service addressed these issues appropriately, we could not see how they were ensuring that agency staff booked in had the necessary skills and competencies to carry out their work.

There were not always sufficient staff members available to meet people's needs safely. The manager told us they heavily relied on the use of agency staff to support people. The use of agency staff was 'block' booked in advance and was commissioned in shifts for example 7-2pm and 4pm-11pm. People told us "I get a lot of agency people, but I don't understand why as regular staff tell me they sometime have to go to the office or take annual leave as agency hours are pre booked." Morning, evening, and weekend calls were difficult to cover and recorded either as late or missed visits. One person said, "Weekends are a real hit and miss. They are very thin on the ground at weekends." People told us they received phone calls from the business centre asking if they really needed a visit. One person said, "I felt pressure to say no as I knew they were struggling." Another person told us; "I know of lots of staff who have left as they just have had enough and can't meet the demand." The manager told us that they had 'contingency plans' and utilised all available resources but once they had utilised all their resources they could not always 'cover' some of the remaining visits and these were 'missed' visits.

Staff and people using the service told us that the business centre that controlled the care rotas was to blame for missed and late calls. Many of the missed visits became known after they had happened. People

told us that staff were expected to travel great distances between visits, when there was other staff living nearby. One person said, "They apparently had 3 people needing morning support in a block of flats, and one of the staff on duty lived down the road. Instead of sending them, they sent three different carers to support the three people, who lived miles away. The girl living down the road had to go miles away for her calls." Another said, "They get phone calls from the business centre constantly asking them why they are not at the next visit while they are with me, they don't seem to care that they have only been with me for half the time I'm allocated."

One member of staff informed us that "They are always adding on visits and I end up giving people breakfast at lunch time," another told us, "Sometimes I do go into people very late for bedtime visits, like 23:15 hours, as I can't get there any earlier." Another member of staff told us "When we call the business centre to say we are struggling they just tell us that we are putting people at risk if we don't go" We saw evidence in supervision notes that care staff had complained that they were unable to do their jobs properly as there was not enough time as early as June 2015.

These failings are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Staff told us that they did not feel they were providing an 'enablement service' they did not have time to 'enable' people but they usually just completed tasks for people as this was quicker and allowed staff to complete all the visits assigned to them during their shift. Staff told us there was a lack of consistency around which people they supported and they could not monitor effectively people's progress through the re-enablement service, and this may have affected their ability to provide effective and appropriate support to people who used the service. There were care plans in place in people's notes to record progress that had been made with re-enablement, but in all those reviewed these were empty. Staff told us, "We haven't the time to fill these in anymore, although we used to."

Staff had received some training but this did not correlate with the providers training matrix. Refresher training was not provided in a planned or methodical way. For example, we saw that not all staff had completed re-enablement training and this was the focus of their service contract. In addition, only five staff had been trained in basis life support and 30 staff had not had recent safeguarding training. This lack of training affected staff skills experience and may have prevented them from supporting people effectively.

Staff had recently had a training update in medicines following a number of errors around the administration and recording of medicines, but MAR sheets remained difficult for staff to navigate. This was also evident in observing an assessor review a person's re-enablement plan. Rather than a review of progress and need, it was to inform the person when the service would terminate and how to access other care services. It was not evident that they had received sufficient training to adequately assess that individual's progress and needs.

These failings are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that although there was a robust and comprehensive supervision policy and procedure in place, it was not implemented effectively. Staff did not have regular one to one support meetings with their line manager, so although there were problems with the service, staff did not always get the support or an opportunity to discuss them and this affected staff morale. One person using the service told us "The staff are all fed up and stressed. I know of two that have left recently as they just can't put up with it anymore." Staff told us that at one time they had attended 'team meetings' however those too had fallen by the wayside.

Staff occasionally phoned the business centre to discuss people who used the service but this was not an effective way of supporting staff and information was not always shared appropriately with other staff. There had recently been a group supervision support, but staff told us this was to talk about problems the service had, rather than to focus on individual competencies and need." When supervision notes were found in staff files, they demonstrated that staff had been voicing concerns about the pressure of the work and how the rotas were organised. This included the late calls, not being able to carry out their role due to time pressures, however no action had been recorded and taken to address these concerns and there was no

follow up.

Staff were aware of the need to obtain peoples consent and told us they always explained to people what they were going to do before providing support. However, people's mental capacity had not been considered when cancelling visits to people due to lack of staff. For example, a person identified as having dementia, lacking capacity and needing full assistance within their care plan, was asked if they required a visit. It was documented they had stated they did not need the visit. Consequently, there was a lack of consideration for individual risks and needs.

When someone is unable to consent the Mental Capacity Act (MCA) 2005 applies. The MCA is a law to protect people who may lack capacity to make decisions and it sets out what processes must be followed in these circumstances. As people received a constant change of staff it was difficult to see how capacity would be considered as, staff told us they just had to get in and out in order to get to the next person. We did not see any recorded assessment of individual's mental capacity or any best interest's decisions in order to ensure decisions were made in a manner, which reflected the person's wishes and preferences.

These failing are a breach of Regulation 11 HSCA 2008 (Regulated Activities) Regulations2014, Need for consent.

People's nutritional needs were sometimes neglected due to missed and late calls. For example, between January and March 2016, we identified missed calls for people requiring support with meals, including a person that required a fixed time appointment due to diabetes. As calls could be very late, people could also find that their breakfast and lunchtime call would be too close together in time or they would forfeit one of these meals. One person said. "I end up missing meals sometimes as they are too close together and so I send the girl away." Another said, "It's my only hot meal of the day as I cannot lift. They have missed breakfast and lunch before now which left me feeling unwell. Another said, "It's not so bad now as I can do more for myself, but when I started I could not get out of bed I relied on them for my meals, but they didn't always show up."

Requires Improvement

Is the service caring?

Our findings

Whilst most people said the carers were very kind and helpful, all people we spoke to told us that carers were stressed and very open about the difficulties they were having to meet people's needs. This resulted in people feeling that they could not ask for additional help or that they would have to shorten their stay by reducing the amount of tasks in order to help staff get on. One person said, "They are so stressed out these poor carers I hate to ask them for anything else." Another said, "They are so rushed all the time it makes me feel rushed too."

There was an inconsistency in the standard of care reported too. One person said, "Some carers are really nice, but some just want to be quick as possible." Another said, "One person refused to come when I needed them, unlike the others. They were really dismissive of my needs and unkind. I reported it but nothing was done." Other carers told me that the carer was like that with other people." People told us information about other people at the service that they had been told about by staff. Consequently, we could not be sure that staff had protected people's confidentiality appropriately.

People told us that staff maintained their dignity when they provided support by ensuring they felt comfortable when providing personal care. One person said, "They really try and do their best with the time they have," another said "Most of them make sure I am left comfortable and have all I need, some will even stay over their time to make sure. But there are the odd few that aren't very good." People reported a variation in the standards of agency care. Whilst some said the agency staff were very caring, others made statements such as, "They are not as good as the regular staff, they don't care as much," another said, "Often they don't speak very good English and I get one word responses, they don't know understand what I need." The provider had recently dismissed two agency staff due to concerns about behaviour, including not turning up to calls.

The records we viewed did not state if this person had been asked whether they had any preferences of who provided their care. This meant that the provider had not considered people's dignity in the planning of their care. People told us that they had been asked if they would prefer a male or female member of staff, but even when they had said they did, this was not always facilitated. One person said, "[Person] is elderly and wanted females, but sometimes men show up and they [Person] declines care and goes without a wash."

People told us that they often did not know who was coming to provide their care until they arrived at the door. One person said, [Person] is very elderly and goes to bed early, but sometimes the night calls were very late so we had to stop them. One night around 2330 hours [Person] awoke to find a male carer in her bedroom doorway. They had come in the house by accessing a key safe. [Person] was absolutely terrified." Another person said, "I got a call at nearly midnight asking if they could come and give me my care. Too late, I had gone to bed and it had been a struggle. In the end I stopped the night time visit."

People told us that generally, that staff were kind and knew how to support them. However much of the feedback we received from people was about the lack of continuity of staff and continuous changes of staff. Staff also confirmed that they were regularly moved around so they did not see the same people. This

affected staff being able to develop relationships with people and ability to monitor people's progress in terms of re-enablement goals. The impact of this regular uncertainty affected people's quality of life.

We found staff to be caring for example during our visits with care staff, they were kind, and caring to the people, they were supporting. One person told us of their care worker, "Make sure you give her a good report, she makes my day." However, people were less happy with the way the business support centre responded to them and on occasions felt that they were spoken to in an abrupt and rude manner. One person told us that they contacted the office to report a missed call. They told us they did not get a letter or an apology, "They didn't seem to care at all that [Person] had not eaten due to missed calls, they were abrupt and uncaring." Another person told us. "I never bother to call them now, they couldn't care less." The impact of this regular uncertainty affected people's quality life.

Inadequate

Is the service responsive?

Our findings

Staff told us they get a list of people they are to visit. One staff member told us "They are all over the place." "We could not get all the visits covered if we provided the care in the order the information is sent to us on CACI (CACI is an electronic hand held rota system). Another member of staff told us "We sit down with a route planner and plan the visits geographically otherwise we would be travelling more of the time that we would be delivering care."

We reviewed the staff rota for two people and saw that they had been assigned 11 and 12 visits respectively that day, some morning and some lunchtime visits. Information provided varied and was not detailed or personalised. Staff told us they usually found out peoples requirements when they arrived at the home. People told us that due to the constant changing of staff they had to consistently explain their re-enablement needs. One person told us, "It's exhausting to keep explaining yourself. They don't bother to read all the way back for information, just what the carer has done before." Other person said, "The staff member had spotted a pressure ulcer and documented for it to be followed up but this never happened. We found out accidentally that [Person] had a pressure sore and then we contacted the district nurse team." This approach also demonstrated that people were not involved in the planning of their care as staff just changed the times around so that they could fit the visits into their shift.

Staff said they were able to feedback issues and concerns to the business centre but that changes in people's need were not always feedback to the lead coordinator. We found examples of where people's needs had changed but that this had not been communicated back to the office. This meant that when a change occurred people's needs could not be reassessed and met. When we spoke to the registered manager about this, she told us this had been a problem since the business centre became the point of contact in April 2015.

A registered nurse told us that they had struggled to get information about changing clinical needs of people reported to the business centre by staff. They had, had to tell staff to inform the nurse directly, contrary to the provider's procedure. Staff told us they reported concerns and changes to both the office and the business centre, but not at the same time. They told us it was a confusing process that meant that information was missed. However, the registered manager was hopeful that planners would be relocated to the Essex Mid office following similar concerns in other areas. Therefore she could regain some control over information coming in.

People we spoke to told us that the initial assessment visit did not always take place on the day that the person returned home, which meant that carers delivered care without adequate assessments being in place. We saw that the provider had not carried out assessments of people's care needs before care was provided. One member of staff said, "We just go in and read what's needed and get on with it." However, people reported that some newer staff had did not speak or understand English very well so it was very hard to explain to them what they needed. One person said, "I asked for a type of breakfast and got something completely different." Another said, "The foreign people are lovely but they don't understand me so sometimes I can't be bothered to explain and go without the care I need instead. They don't always read the

book."

When we asked staff how they knew how to care for people they told us that they read the daily notes before from the previous day, but these notes would just state what tasks had been completed. For example, a person told us that they were feeling very low in mood, and staff confirmed this was usual. Staff did not document how people were presenting and this would then make it difficult to for assessment and review coordinators to look back at notes and determine if any additional support was needed.

Assessment and review coordinators visited people in their homes during a six-week re-enablement plan to review the care and adapt care plans. However, we observed this taking place and there was little assessment of those persons on going needs. The coordinator gave notice of termination of care and advised how people could access additional support. If changes were needed a note for staff was left on the front of the folder. Care staff told us that this was because we do not have time to look through all the paperwork.

People's care plans did not all contain the person centred information that care staff required in order to get to know people and provide personalised support. People's care plans did not contain relevant information about their life history, their home and family, and anything important to them. Care plans were generic, focused on tasks, and did not reflect the different strengths and limitations of each individual.

The process for reviewing care plans was not robust. The registered manager told us that assessors visited people to review the progress that people are making. This was not recorded, and the records we checked did not contain information about how people had progressed to live independently again. One senior care staff had highlighted in supervision that they felt unable to complete their job properly, this included reviewing people, but no actions were taken to address these issues.

Risk assessments were not always completed and when they were completed these were not always reflective of people's needs. For example, a professional's assessment may have highlighted that the person is at risk of falling but the risk assessment conflicted with this view. In all care plans, and reviewed risk assessments were not all completed. Therefore, the provider had failed to make sure that people received care and treatment that appropriately met their needs, and reflected their preferences.

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

The provider had a complaints policy and procedure, although this was not always followed in practice. The manager was unable to demonstrate how they had analysed complaints to identify trends to drive improvements in the service.

The manager told us people had a care record that contained information about how their needs should be met together with other information about the service, which was kept in their home. The care records we reviewed in people's homes did not always contain information explaining to people how they could make comments, compliments, or complaints.

Many complaints had been around missed and late calls, inconsistency of care staff, and the impact of this on people. The provider apologised for any upset incurred in responses, however the issues continued. People told us that they knew they could make a complaint, but not everyone was clear about the process. One person said, "I have made so many complaints, and then finally we got a set time and were prioritised due to medication, but I must have phoned to complain frequently." Another said, "I've made complaints but nothing gets done." One person told us that they had complained about a member of staff but had not

heard anymore.

The provider's complaints file did not always record complaints entered into people's care notes. These had not been subject to the provider's complaints procedure and had not been formally recorded as complaints. This meant that not all people's concerns and complaints were explored and responded to appropriately.

Most people told us they received different carers daily. Some people told us that they had asked for a female carer but had sometime been sent male carers. Care records were not consistently clear about the timings agreed for people's calls, and peoples request for specific times were not recorded. Compliant investigations clearly demonstrated that some people had not had their needs met at the right times for them and that delays in receiving care had put people at risk. One person said, "They do ring to let me know but staff sometime arrive very late."

We saw that in a feedback survey in September 2015 that quality issues such as; missed calls, disorganised office staff, problems with hand held devise CACI, rota planning, no consistent staff, lack of organisation have all been identified through complaints, staff raising concerns and local authority feedback. However, we saw that no action was taken to address the concerns and no improvements had been made.

The provider's failure to record, investigate, and take proportionate action in relation to complaints was a breach of Regulation 16 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did try to provide support and information for people to access additional services following termination of re-enablement care. Care folders contained a list of home care agencies with contact information. Assessment and review coordinators would attend people's homes to give 28 days' notice of care and if that person needed additional care after this time, the coordinator would refer them to the list of agencies. The service were professional in delivering this information and we observed staff informing people that if they needed help to make a decision they could check the Care Quality Commission website for ratings. They did not recommend services to people.

Inadequate

Is the service well-led?

Our findings

The provider did not have appropriate systems in place to monitor and assess the quality of care to protect people. The provider was aware of some of the concerns that we had raised at the inspection but did not have the appropriate systems in place to accurately collect, record, and analyse the information to take appropriate action.

People and staff had been raising concerns about how visits were organised for a considerable period but the provider had not taken action to address these concerns. The management team told us that some aspects of the service for example the assessment and planning aspect was 'managed' from the BSC (Business Support Centre) and therefore they did not have direct responsibility for this aspect so when things went wrong it was an onerous process to try and get things sorted out. For example, missed visits or where people had chosen to have a female worker this information was not always communicated effectively which resulted in people refusing a service and therefore being placed at risk.

There were no effective systems in place to check that people were receiving the appropriate care in line with their re-enablement package. A number of people told us that they had stopped part of their service as the inconsistency of staff and visit times varied so considerably that this interfered with their recovery. One person said, "They were supposed to help me to bed, but I would be left waiting for hours and sometimes they would never show." Another person said, "I had to make several complaints to the business centre before they would allocate a fixed call to [Person], even though [Person] needs medication at specific times. We have to come daily to support [Person] ourselves." The constant changes in staff assigned to support people did not support the re-enablement process. Staff told us they struggled to meet re-enablement goals due to the way their rota's were managed, and consequently just had to get in and complete the tasks as quickly as they could.

Systems in place to manage missed or late calls were ineffective and failed to identify, investigate or action all the concerns identified to improve the service. The management team told us they had been told by the business support centre they had not had any missed calls since December, at which time they had had excessive demand for services, which they could not fulfil and consequently had experienced a large number of missed calls. However, we found evidence of numerous missed calls from January to March within people's complaints to the service, care files and safeguarding alerts. These included when nobody had turned up to provide care to the person and when people were contacted to cancel visits due to shortness of staff. People told us, they got many calls cancelling the service. One person said, "Calls to cancel my service are fairly frequent." This meant that people were not receiving their re-enablement packages.

During visits with care staff, we visited a person whose service had been discontinued and staff continued to be 'assigned visits'. This left the person confused and worried as they had received care from a different agency that morning and they did not know what had happened. Staff told us, "This happens a lot, we show up and are not told that a service has stopped." We also found that staff's rotas were continually been updated and added to during shifts. One person told us, "They get changes to their rotas all the time, even

when they are in the middle of caring for me; it's so stressful for them, especially when they know they can't get to the next person, they might have to go miles out of their way. When they phone and complain they get told to get on with it." People did not receive consistency as visits were 'assigned' to any staff who had available capacity so this meant that staff could not always monitor improvements especially to people who were being supported through the enablement service.

Staff spoke with said that on occasion they worked without breaks. Staff did not always feel supported and did not think the business support centre gave them the information they needed to do their jobs correctly. Staff had been very open with people using the services about their difficulties and people told us, "They hardly ever get a break to have a drink or eat," "The poor carers are literally travelling miles away without need as other carers could be nearer." Several people commented, "They must waste so much money on petrol costs," One person said, "They have no idea how to manage this service."

The provider told us they had experienced a surge in their referrals towards the end of November 2015, due to the number of cases that required on-going support, which the provider referred to as post re-enablement hours. This was also alongside an increase in the number of 'provider of last resort' referrals. The provider had taken action to mitigate some of this shortfall; however, some rotas were not planned or produced in advance so people did not know who was providing their care. This was demonstrated by the difference in the data from the provider and the feedback we received from people using the service. This lack of effective monitoring placed people at serious risk of harm.

The registered manager could not be assured that staff were competent in their role. Traditional manager's responsibilities for overseeing rota's, staff supervision and monitoring the quality of staff performance, were carried out by the provider's business support staff. The registered manager expressed frustration at this, as they felt helpless to ensure that people were receiving the care that they were assessed. Many staff had not received supervision for some time and when they had reported concerns, particularly in relation to how their rota's care calls were managed, these were not acted upon.

One member of staff told us, "If we try and call the business centre to say our rota's are impossible and we won't be able to get to people, they don't understand. They tell us if we don't get to people they assign us then we are responsible for neglecting them." Consequently, staff would reorganise their rotas themselves dependant of location. This meant that risks to people might be overlooked in order for staff to complete their rounds. This meant the provider did not have systems in place to assess, monitor, and improve the service to ensure that risks to the health and wellbeing of service users were mitigated.

The 're-enablement service' sent out senior assessment staff (ARC's) for a mid-evaluation. However, we observed that they were not assessed with regard to whether they had been effectively supported to achieve their enablement objectives. Alternatively, if the service was meeting what it set out to achieve, this was to support people to achieve optimum independence following an episode of ill health or an accident. Instead, people were given a termination date and information as to how to access additional care. Staff did not receive training in re-enablement care and therefore did not fully understand what evaluation should take place.

The checks in place to ensure that staff were supporting people correctly with their medicines were not effective. Medicine Administration Records (MARs) were in people's homes where they remained until the person's re-enablement package was completed. Staff told us they had great difficulty in understanding the MARS sheets and that depending on which senior staff member had reviewed and updated it, was also dependant on the quality of information staff had about the medications they dispensed. Errors were not audited effectively and staff did not receive routine spot checks to check competency. One member of staff

told us that senior staff had told them to give antibiotic medication that had not been prescribed on the MARS chart, without checking with the GP. A nurse working at the service told us how they had been under pressure from managers to try to train everyone in medication administration. When we reviewed the daily records and MAR charts available, we saw that some people had not received their medicines correctly and others had missed calls that the service had not addressed.

The provider did not take measures to ensure that staff had the right information and where recording interactions appropriately with people. Staff commented that communication sheets were all over the place and "How are we supposed to read everything we need to know when these sheets are all mixed up, I haven't time for this." We saw that in all people's homes that we visited, communication folders were unclear, poorly organised, and failed too appropriately record the service delivered. Staff told us that the assessors would review the folders, but it was clear that this had not been completed effectively. We saw examples of people being high risk of falls but in all cases falls risk plans were left blank.

There was limited information on how the organisation obtained the views of the people who used the service. The registered manager stated that satisfaction questionnaires had been sent out but all the responses had been filed away in a folder since July 2015. They had not had the opportunity to review these, which meant comments could not be fed back into the service to make improvements. People told us they had made complaints about the service but little had been done. We saw that people received a standard written apology, but people told us this did not mean that their concerns had been addressed and they often continued to have late and missed visits.

This lack of robust monitoring meant that issues of missed and late visits were not picked up and addressed in a timely way, and the poor practice continued. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance.

As part of the inspection process we identified that a number of safeguarding concerns that had been raised with the Local Authority safeguarding team. We checked our systems to confirm if the provider had informed the Commission of the concerns and could see that this had not happened. We also reviewed all the complaints received by the provider that had not identified safeguarding concerns around neglect, for example, when people had not received a visit, and this had resulted in vulnerable people missing meals and medication. We discussed this with the management team and who retrospectively sent us 15 historical notification's, around service neglect. Systems to protect people using the service were inadequate, as required notifications were not sent to the Commission as required as part of the regulations.

These failings are a breach of Regulation 18 HSCA 2008 (Registration) Regulations 2009: Notification of other incidents

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents We had not been notified of all the safeguarding allegations and investigations as required by the regulations.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Lack of person centred care

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People who used the service had not received an appropriate and decision specific mental capacity assessment which would ensure the rights of people who lacked the mental capacity to make decisions were respected.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure that people received the care and treatment they needed. People could not be sure that they would receive their care visits and sometimes this left people at risk of neglect.

Regulated activity	Regulation

Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to make sure that people received care and treatment that was appropriate, met their needs and reflected their preferences.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have systems and processes in place to identify where quality and safety of people using the service was being compromised. The Provider did not respond appropriately and without delay to concerns about missed and late calls, and did not have access to all necessary information.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to provide staff with appropriate training and supervision to enable them to carry out their duties.