Firstpoint Homecare Limited

Firstpoint Homecare Coventry

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Firstpoint Homecare Coventry is a domiciliary care service providing personal care to children, younger adults and older people who have learning disabilities or autistic spectrum disorder, mental health diagnoses or dementia. At the time of our inspection the service was undergoing significant change and was reducing the number of people they supported. On our first day of inspection the service was supporting 115 people with personal care. By the second day of our inspection this had reduced to 22 people.
Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

The provider had arranged the reduction in people supported by the service in conjunction with the local authority. Firstpoint Homecare had a contract to provide personal care to people arranged and funded by the local authority.

In early 2019 there had been a large increase in the number of people supported by the service which was arranged by the local authority. The provider acknowledged that they had not been able to manage the care of the increased number of people safely or effectively.

In May 2019 the provider had met with the local authority and gave notice to end the contract, at this point Firstpoint Homecare Coventry was providing support to approximately 200 people. Since May 2019 the provider has worked with the local authority to transfer people to other care providers and the intention was by the end of August all local authority care packages would be moved to other care providers.

On 30 August 2019 Firstpoint Homecare Coventry was supporting 22 people who intend to stay with the service as privately funded clients.

People's experience of using this service and what we found
On day one of our inspection we found risks to people's safety were not always identified by the provider. This meant staff did not always have information available to support people safely. People did not always receive their calls at the expected time and some calls were not attended at all.

We asked the provider to take action to improve the information available to staff about individual risks and to provide daily reports about when care calls were provided. The provider took immediate action to ensure information available to staff about risks was reviewed, updated and available. They also ensured measures were in place to ensure prompt action was taken in the event of missed or late calls.

People were supported by staff who understood how to recognise and identify abuse however the provider did not always follow their policies to protect people when concerns were raised. We brought two incidents

to the provider's attention. In response to this, the provider immediately took appropriate action to safeguard people.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People told us staff had the right skills and training to support them however we had identified occasions when staff had not supported people in line with their training . The provider had recently reviewed how new staff were trained and introduced a longer period for new staff to work alongside more experienced colleagues. This enabled the new member of staff to get to know the person they would be supporting.

People told us staff were caring and supported them in a respectful way. However, prior to our inspection we were informed of concerns raised by people when staff had not acted in a caring way. These incidents had been referred to the local authority to be investigated.

People told us they were not always supported by the same staff who they knew. The provider had already identified this and was working to improve the consistency of staff attending calls. People were involved in planning their care and had this information provided to them in a format they could understand.

People were asked for their feedback of the service, but this was not always used by the provider to drive improvement of the service. Due to management changes at the service people were not aware who the current manager was but they felt they could ask to speak to a manager and concerns would be acted on.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (Published 27 April 2019)

Why we inspected
The inspection was prompted in part due to concerns received about missed calls and the quality and safety of care provided. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive and Well Led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

The provider has taken action to mitigate the risks identified and which has reduced the risk to people supported by the service.

Enforcement

We have identified breaches in relation to managing risks to people, taking appropriate action to safeguard people, monitoring process to ensure high quality care and failure to report incidents to us at this inspection.

Please see the action we have told the provider to take at the end of this report. Full information about

CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Requires Improvement

Is the service effective?

The service was not always effective.

Requires Improvement

Is the service caring?

The service was not always caring.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Requires Improvement

Is the service well-led?

The service was not always well-led.

Requires Improvement

Firstpoint Homecare Coventry

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The first day of the inspection visit was completed by two inspectors. The second day was completed by one inspector. Two inspectors made telephone calls to people supported by the service and staff members.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service did not have a manager registered with the Care Quality Commission. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the first day of inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection. The second day of inspection was unannounced.

Inspection activity started on 07 August 2019 and ended on 30 August 2019. We visited the office location on 07 and 14 August 2019.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. As the date of this inspection was brought forward the provider was not asked to complete a provider information return prior to this inspection.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We spoke with the nominated individual, manager, a field care supervisor and two members of care staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to monitor how they were addressing risks identified during our office visits. We looked at risk assessments, call monitoring records and quality assurance records. We spoke with two professionals who regularly visited the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- The provider had policies in place to protect people from the risk of abuse. However, these were not consistently followed which meant potential risk to people was not always managed. The provider had failed to take action to minimise risks when allegations of potential abuse which involved staff had been shared with them.
- A previous allegation had been made about a member of staff who no longer worked for the organisation. This was investigated by the local authority who had in May 2019 requested a DBS referral was made about the member of staff. The DBS referral would inform potential new employers of the allegation during recruitment processes. The provider was not able to provide us with evidence that this referral had been made. This meant if the person applied for employment in a similar role, people could be put at risk.

This was a breach of regulation 13 (Safeguarding Service Users from Abuse and Improper Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We brought these concerns to the provider's attention who immediately acted in line with their policies to remove staff from working with people until safeguarding investigations had been completed. The provider also completed a DBS referral and provided us with a copy of this .

- Staff told us they had received training about recognising and how to report abuse. They told us this training was reviewed every year.
- The majority of people told us they felt safe with staff. However, one person told us there had recently been changes in the staff who supported them. This meant they did not know the staff members, and this made the person feel unsafe.

Assessing risk, safety monitoring and management

- Risks to people's safety, health and wellbeing were not always assessed to ensure they received consistent, safe care. Whilst this ineffective management of risk was not known to have caused harm to people or staff, it created a significant potential risk which was of concern to us.
- Individual risks were not always assessed, and relevant information was not always available to staff. For example, one person had epilepsy and experienced regular seizures. This was not recorded in their support plan and information to staff was not available about how they should respond if the person experienced a seizure whilst staff were supporting them.
- Another person had diabetes. There was no information for staff about how to identify signs that the

person's blood sugar was too high or too low and how to respond to this.
● During our first day of inspection we asked the provider and manager for a list of all those people they supported who were diagnosed with epilepsy or diabetes or who were prescribed time critical medicines. The provider and manager were unable to give us this information.
● When support plans and risk assessments were in place, staff did not always follow the guidance. One person required the use of a hoist to move from their bed or a chair and had a detailed support plan which informed staff how to use the hoist safely. However, the local authority had been informed by a relative that staff members had not followed these instructions and had used the hoist in an unsafe way.
●We were also made aware of three incidents where people who required soft or pureed diets were given food that was not the correct texture, creating a choking risk. For each person detailed instructions were in place to inform staff what they could not eat. In response to this the provider had met with the staff involved and re-emphasised the importance of following the guidance in the support plans.
● Information obtained during care reviews was not always used to ensure known risks were managed. For example, in June 2019 a care review for a person had identified they had a 'bed sore' on their right ankle and left heel. District nurses were visiting daily to dress the wounds and an occupational therapist had visited the person in July 2019. Despite these risks being identified, the person's skin integrity risk assessment had not been reviewed since 26 September 2017 and a skin integrity care plan was not in place. The provider acknowledged this risk and assured us they would take immediate action to address this shortfall.
● Care staff were required to use an electronic system to notify when they arrived and left each call. However, the majority of staff did not use this system which meant office staff were unable to accurately monitor if calls were attended on time or if they were missed. People told us their calls were not always on time. One person explained they were meant to have a morning care call at 8am, however there had been occasions when staff did not arrive until 10am .

This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our first day of inspection we asked the provider to send us details of how many people they supported who were diagnosed with diabetes or epilepsy or who received time critical medicines. We also asked that these people's support plans and risk assessments were immediately reviewed to include information for staff about how to respond to these risks. The provider sent us this information and completed these reviews following our first day of inspection.

Learning lessons when things go wrong
● The provider told us they were keen to learn lessons when things went wrong. They explained that in their view their current contract with the local authority had put enormous pressure on the service which had resulted in people receiving care that fell below their expectations. They explained that the contract would be ending at the end of August 2019. They said, "FirstPoint have handed back the lead provider contract to [Local Authority]. It wasn't working and caused lots of complaints and issues. We are all over the place and will learn from it."

Staffing and recruitment
● The provider acknowledged that they had struggled to maintain enough staff to meet the obligations of their contract with the local authority and that had been one of the reasons to end their contract. At the time of our inspection most people supported by Firstpoint Home Care Coventry were having their care packages transferred to other care providers. The provider told us they had enough staff to meet the care needs of each person they were currently supporting, and as the number of care packages continued to reduce, this would become increasingly easier to manage.

● The provider told us that they expected to have reduced the number of people they supported to approximately 20 by the end of August. As of 30 August 2019, the number of care packages had reduced to 22.
● The provider acknowledged that care calls had been missed in the weeks prior to our inspection and in the time between our site visits. The provider told us this had been due to staff not identifying changes in their rotas which were being updated daily as packages of care were transferred. They assured us there were enough staff to attend all calls.
● Following our second site visit we wrote to the provider and asked them to provide us with daily reports which identified any missed or late calls as well as the total number of people they were providing care to. The provider completed these reports and there were no missed calls. There had been some late calls due to unforeseen circumstances, however these had been attended within 30 minutes of the agreed call time.
● Staff were recruited safely, and pre-employment checks were completed to assure that the people employed were suitable for the role.

Using medicines safely
● Instructions for "as required" (PRN) medicines were not in place to ensure people received their medicines when they needed them. For example, one person was prescribed a topical cream and paracetamol on a PRN basis. There were not guidelines to inform staff when to administer those medicines to ensure the person did not receive too much or too little. There was no body map to inform staff where to apply the cream to the person's body. We discussed this with the provider who immediately reviewed the person's support plan and updated the information.
● Audits of medicine records were completed and had identified staff did not always follow the provider's medication policy. For example, staff had not signed the medication administration chart to confirm they had given people their medicines. Action taken to address these issues was not robust enough to provide assurance that staff were always recording when they gave people their medicines.
● One person's medication support plan contained conflicting information about whether they were able to take their medicines without support. This meant the person may not receive their medicines as prescribed.
Preventing and controlling infection
● We saw gloves and aprons for staff to use were available in the office.
● Prior to our visit we had been made aware a member of staff did not have any Personal Protective Equipment (PPE) which meant they were not able to empty a person's catheter bag. We spoke to the provider about this who assured us PPE was provided to all staff. They told us their care staff had not completed the task because they were rushing the call. In response to this the staff members involved had received further training and the issue had been discussed with them during supervision.
● People told us that staff wore gloves when they were supported with care.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People and where appropriate their families had been involved in an assessment of their care needs before their service had started. Where possible people had signed to confirm they agreed with the assessments.
- People's protected characteristics under the Equalities Act 2010 were identified as part of their need's assessment. This included people's needs in relation to their culture, religion, sexuality and disability.
- However, information gathered during assessments had not always been used to effectively manage risk. For example, one person had epilepsy and diabetes. These known risks had not been assessed to ensure they received safe and effective care.

Staff support: induction, training, skills and experience

- Observations of staff practices took place. However, these were not effective to drive forward improvement. For example, a spot check of one member of staffs' practice had been undertaken in July 2019. The check had identified several shortcomings in the staff member's practice but none of these were discussed with the staff member in a supervision meeting held with them on the same day. .
- Staff received training when they began working for FirstPoint Home Care Coventry. A member of staff told us the training "covered a lot and I learnt more than with previous employers. I got to use practical equipment and had practical training too."
- Although staff spoke positively of the training they received we identified there had been occasions where they had not followed the correct methods in areas of their work. We have reported on these in 'Safe'.
- The provider had recently reviewed the induction process and new staff were now given a longer period to work alongside a more experienced member of staff. The manager explained this would enable new staff to get to know people and to gain confidence.

Supporting people to eat and drink enough to maintain a balanced diet

- People's dietary needs, likes and dislikes were recorded in their care plans. ● Guidance was available for staff to ensure people were supported to eat safely. For example, they need to help someone to eat using a teaspoon. However staff did not always follow the guidance provided and we have reported on this in 'Safe.'

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People had access to healthcare professionals and people told us staff supported them to make appointments with healthcare professionals when necessary.

● Care records included evidence of health and social care appointments. For example, where needed, people had been reviewed by their GP, optician, diabetes nurse and occupational therapist.
● The provider told us they were working with the local authority and other providers to ensure that care remained consistent whilst they moved to new providers.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA
● Decision specific mental capacity assessments had been completed when required. The provider understood that a capacity assessment only needed to be completed when they had concerns in relation to people's capacity.
● People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.
● People told us staff asked for consent before providing support.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Prior to our inspection we had been informed by both the provider and commissioners that people had raised concerns about how they were supported. One person reported that a member of care staff had spoken to them in an abrupt manner which had caused them to feel "anxious and upset."
- The provider told us, "Our value is to deliver best care possible in the community. The lead provider contract has impacted on our values. People haven't received good care and we want to go back to basics." The provider acknowledged that by not ensuring people received their calls at the correct times they had not demonstrated a caring attitude.
- People we spoke with told us they thought individual staff members were kind and supported them well. One person told us "They [care staff] are good company and always have a chat with me. They always remember what I say and ask me about it." Another person spoke positively about the care they received, "I know what good care is and I receive it."

Supporting people to express their views and be involved in making decisions about their care

- People were involved in the care they received on a day to day basis with the care workers supporting them. People told us they were asked about their views in care plan reviews.
- People's care plans reflected their involvement. Care records contained information about people's past histories and lifestyle choices.
- No-one was using advocacy services at the time of our inspection as people's families were involved. However, the provider informed us they would support people to access advocacy services if needed. Advocacy services offer trained professionals who support, enable and empower people to speak up.

Respecting and promoting people's privacy, dignity and independence

- People's care plans informed staff how they needed to maintain people's dignity. However, we had received information that staff did not always follow these instructions, for example a member of staff did not empty a person's catheter bag.
- People's right to privacy was respected. One person's care plan advised staff to knock on the door and wait for the person to answer before entering. Staff gained entry to another person's home by using a key safe. The person's care plan advised staff to announce their arrival once they had opened the door to the person's home.
- Care plans informed staff how to promote people's independence. For example, it advised staff what parts of their body people could wash for themselves and what they needed help with.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- The service was not always responsive to people's needs because people did not always receive their care at agreed times. On occasions people's calls had been missed which meant some people had not had their care needs met. One person told us, "One carer didn't turn up at all." They went on to say that for the two months prior to the inspection, call times at weekends are "Pretty bad. It's all gone haywire."
- The service was not always responsive to changes in people's needs, we have reported on this in "Safe"
- The provider acknowledged that in the time since our last inspection there had been a lot of changes. They felt, however that overall, "We have good continuity of care." They went on to explain that some people had asked not to change providers and wanted to stay with them because of the continuity of staff they received."
- Records showed overall, people received care from familiar staff. For example, one person had received 28 care calls between 3 and 6 June 2019. Their care had been provided by four consistent care workers. However, one person told us how they had not received consistent care workers, and this had made them feel unsafe.
- Care records contained information about people's lifestyle choices and preferred routines. In one person's support plan it stated, 'I would like the carers to support me every day with a full body wash and once a week assist me to wash my hair.' Another person's support plan stated, ''My religion is important to me. I visit church on Sundays.'

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The provider told us they were able to provide information to people in a style which suited them, for example in a different language or in large print.
- People's communication needs had been assessed. For example, one person wore hearing aids and glasses. Their care plan informed staff to make sure the person was wearing them. Care plans also advised staff on how people liked to be greeted.

Improving care quality in response to complaints or concerns

- People were aware of how to make a complaint and told us they would raise concerns with the manager. There was a record of complaints and details of how these were responded to in line with the provider's policies.

● The provider had identified that the increase in complaints received was because they were unable to manage the number of care packages from the contract with the local authority. The provider had taken steps to end the contract with the local authority and planned to return to providing care to a smaller number of people.

End of life care and support

● At the time of our inspection no one was receiving end of life care. However, support plans included information of how people wanted to receive care at the end of their life. This information included decisions about medical interventions and any religious or cultural practices they wanted to occur.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Governance systems to monitor the quality and safety of the service were not effective. The electronic system to monitor the arrival and departure times of care workers at people's homes was ineffective because some staff were not using it correctly. Although the provider was aware of this they had not taken effective action to ensure staff complied with the system. The provider told us they would no longer be using the system after the end of August 2019.
- The local authority required the provider to use the system and a 90% compliance rate was required. Between 22 July 2019 and 4 August 2019, 511 care calls had been completed. Only 45% of people's calls had been logged correctly using the system.

- Checks of care records were not always completed and when they were, they did not always identify when information needed to be updated.
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This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed these matters with the provider who was aware that the effectiveness of their governance systems had deteriorated in the time since our last inspection. They told us that in their view this was due to taking on too many care packages and not having the resources to monitor these efficiently. To address the issues the provider had decided to end their contract with the local authority and to hand back most of their care packages. The provider told us the organisation was no longer upholding its own values of high-quality care and that by reducing the number of people they supported they would be able to provide this again. The provider explained the difficulties they had encountered whilst working as a provider of care for the local authority.
Following the second day of our inspection visit we wrote to the provider and requested that they sent us a daily report detailing how many people they were supporting and any missed or late care calls. The provider completed this and during this time we saw that the number of people they supported decreased to 22, no care calls were missed and although some were late, these were delivered within 30 minutes of the expected call times and no harm was caused to people from the delay .

- Providers registered with CQC have a responsibility to inform us about certain events without undue delay.

We identified that we had not always been notified of these incidents. We were not informed when a person who required a pureed diet was given food that was unsuitable for them and posed a choking risk in June 2019. We were also not informed of an allegation of abuse in July 2019. The provider had referred these incidents to the local safeguarding team.

This was a breach of Regulation 18 (Notifications of other incidents) Registration Regulations 2009

● There was not a registered manager in place at the time of our inspection. The previous registered manager voluntarily deregistered with CQC in March 2019 but continues to work with the service as a training and recruitment manager. A new manager was recruited however they left the organisation in May 2019 before they had registered with CQC. The provider informed us that the previous registered manager intended to apply to be the registered manager again.
● Staff told us they worked well and communicated well with each other, however they found the recent number of changes to their rotas confusing.
● Although staff told us they were aware of their responsibilities and accountabilities we identified that they did not always follow the guidance they were given on how to support people and did not use they systems as expected by the provider.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The provider wanted to improve how they involved people and relatives in planning their care and to improve communication and was in the process of implementing an electronic care system. The system used an app downloaded onto staffs' smart phones. The app contained important information about people including their care plans. The provider told us it would help to improve the quality of care people received. They said," It's a live system so we can keep on top of it. We will have more time to monitor more closely moving forward." The provider also told us that people's families and health professionals would be able to have some access to the system which would improve communication.
● People told us there had been a lot of changes to the service in recent months and felt confident that if they reported concerns to "the office" they would be acted on. However, they were not aware who the manager was.
● Staff told us they were aware of the provider's whistle blowing policy and they would use this if they had any concerns about the service.
● Staff told us that the amount of change occurring in the organisation was unsettling and was impacting on staff morale. One member of staff told us "Everyone is worried at the moment; a lot are looking for other jobs or have left." Another member of staff said, "We're all on tenterhooks, people are panicking that there won't be much work left."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider understood their responsibilities under the duty of candour. During our inspection the provider was honest with us about the difficulties they had experienced and how they intended to improve the service. We saw evidence that when things had gone wrong these were discussed with the people involved, or their relatives, and they were also informed of any actions that were taken.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The provider regularly gathered feedback from people via telephone calls and reviews, but action was not always taken in response to the feedback gathered. In May 2019 five people had provided feedback that

their calls did not always take place at the expected time. Comments included, 'carers don't stick to specific times does not know when they will arrive. ' 'carers come at different times each day. 'Do not arrive on time.' At the time of our visit this was an ongoing issue.

● Some feedback gathered by the provider was positive, people said "Our carers are friendly, caring and kind;" "Couldn't fault the carers. Don't know what I would do without them;" and "No concerns carers are lovely. No problems or concerns."

● Staff told us they usually had regular meetings with their supervisor to discuss their work and if there were any improvements they could make. Staff told us that with the changes to the service these had not been as regular in the last few months, however they said the manager was approachable and that they could go to them at any time with any concerns or suggestions.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services were not protected from risks because of incomplete or inaccurate information in their care records.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not consistently follow their own policies to safeguard people when concerns were raised.