Care Quality Commission

Dignicare Limited

Dignicare

Inspection report

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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**

Overall summary

Dignicare provides a home care service to people living in Keighley, Bingley and Craven areas of Yorkshire. On the date of the inspection, 77 people were using the service.

A registered manager was not 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 and associated Regulations about how the service is run. A new manager had been recruited who was in the process of applying to become the registered manager of the service.

At the last inspection in September 2014, we found breaches of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Regulation 9 (care and welfare), Regulation 10 (assessing the quality of the service provision) and Regulation 22 (staffing). During this inspection we found breaches continued in all of these regulations.

Summary of findings

We found 13 people were not always receiving care in line with their assessed needs. Call times were often erratic and unpredictable from day to day. The consequence of this was people did not always receive assistance with key care tasks such as medication continence, mobility and food at times which ensured their safety and met their individual needs. Records showed that for eight people, there was a tendency for evening calls to take place earlier than planned and/or morning calls later than planned which meant these people were often left without support overnight for unacceptable amounts of time.

Staffing levels were still a concern and we judged the lack of staff was responsible for the erratic nature of call times. For example, rotas revealed that one person who should have received their morning visits at 8am were on the rota as late as 10.00am indicating there were not enough staff to meet people's assessed needs. Following the inspection the provider told us it was withdrawing from providing care in the Keighley area as it did not have sufficient staff.

We found the quality assurance system had not improved and there was still a lack of process in place to assess and monitor the quality of the service. There was no system in place to promptly identify and measure the number of missed calls. Care records were not robustly audited, there were no audits of the medicine management system and we found significant risks in these areas.

Medicines were not safely managed. An accurate record was not kept of the medicines each person was supported with. This meant it could not be verified whether people received their medication as prescribed. Medication was not considered in the planning of visit times and we found erratic call times put one person who received support with time specific medication at risk.

People did not always receive consistent support at mealtimes with food and drink. The erratic nature of call times meant people received an inappropriately small gap between their morning call where breakfast was prepared and their lunchtime call. We identified five people whom this had effected, including observing one person given their breakfast and lunch during the same visit.

People's capacity was not assessed in line with the requirements of the Mental Capacity Act (MCA). Where relatives had signed to consent to plans of care, capacity assessments had not been undertaken to determine whether the person had the capacity to make care decisions themselves.

People told us staff were caring, kind and friendly when they visited and most people cited staff attitude as the best thing about Dignicare. However, we found people were not informed if staff were going to be late and this caused some people upset and worry.

There was no effective system in place to record and action verbal complaints. 9 out of 16 people we telephoned told us they had "major concerns" about call times. One person told us a meeting with management had not materialised, another person told us the manager was rude to them and a third person told us that no action had been taken to address their complaint.

We found a number of breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we asked the provider to take at the back of the report.

Summary of findings

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 did not received calls at times that ensured their safety. Eight people were on occasion left without support overnight for significantly longer than stated in their care assessments which increased the risk of harm

Medicines were not safely managed. Record keeping was poor, with no record of the individual medicines staff administered to people. This meant in many occasions we could not confirm whether people were receiving their medicines correctly. We found instances of medication being administered by some staff without appropriate training increasing the risk to people.

Safe recruitment procedures were not followed. Three staff raised concerns with us that some staff had started work without the completion of required checks. Documentation we saw confirmed two staff had started work without completion of the required checks such as referencing and disclosure and barring checks.

Is the service effective?

Inadequate

The service was not effective.

People told us that staff skill and knowledge was inconsistent and some staff did not have the required level of competence. We saw incidents had occurred such as staff not fitting/using equipment correctly which confirmed this was an issue. Staff were not up-to-date in key training topics and the staff we spoke with had a variable knowledge of the subjects we asked them about.

People's capacity was not assessed in line with the Mental Capacity Act (MCA). Where relatives had consented to plans of care there was no documented evidence people's capacity had been assessed and any care decisions made in their best interests. We found valid consent had not always been obtained in asking people about their preferred call times.

We saw evidence the provider was in contact with external health professionals and recorded their advice. However, we found call times were erratic and as such did not always meet people's healthcare needs. The impact on people's health of changing call times had not been assessed

Is the service caring?

Requires Improvement

The service was not always caring.

People reported that staff were kind and compassionate, friendly and treated them well. People told us that the attitude and personalities of staff was the best aspect of Dignicare.

However people told us staff did not contact them if they were going to be late or if the visit time was changed. People told us this caused them upset and worry. The erratic and unpredictable nature of call times was not conducive to a caring service.

Summary of findings

Is the service responsive? The service was not responsive. People did not receive care in line with their assessed needs as we found 13 people received call times and/or missed visits which did not always meet their individual needs. This meant people's mobility, nutritional, continence and medication needs were not always met by staff. Care documentation both in the office and in people's homes was out-of-date and was not always an accurate reflection of people's individual needs. For example during home visits only one out of eleven people had an up to date plan of care. This meant there was a risk that inappropriate care was provided as there were not clear instructions for staff. Verbal complaints were not always documented and we found there was a low level of satisfaction with the service.	Inadequate
Is the service well-led? People's views about the quality of management were mixed. Although some people said they were helpful, others said they had not addressed their concerns or met with them as promised. The service did not have an adequate system of quality assurance to regular assess the quality of its service. There was no system to check people were receiving calls at appropriate times. There was no system to promptly identify missed calls. Care records and the medication management system were not robustly audited. This lack of robust monitoring meant there was the ongoing risk people received inappropriate care or treatment	Inadequate

Dignicare

Detailed findings

Background to this inspection

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

At the last inspection in September 2014, we found breaches of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Regulation 9, Regulation 10 and Regulation 22. Following the last inspection the provider sent us an action plan detailing the improvements it would make to ensure compliance with these regulations. As part of this inspection we checked whether the provider had made these improvements.

The inspection took place between 7 and 23 January 2015. During this period we made phone calls to staff and people who used the service. We visited the provider's offices on 7 and 19 January 2014 and visited people in their homes on 13, 15, and 16 January 2015.

This was an announced inspection. The provider was given 48 hours' notice because the location provides a domiciliary care service and management were not always office based.

The inspection team consisted of three inspectors, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with 24 people who used the service or their relatives. This was a mixture of telephone calls, and visits to people's homes. We spoke with seven care workers, the office manager, manager and provider. We looked at six people's care records during the office visits and 11 people's care records during home visits. We looked at other records which related to the management of the service such as training records and policies and procedures. As part of the inspection with also spoke with the local authority safeguarding and commissioning teams.

We did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection, we reviewed all the information held about the provider.

Inadequate

Is the service safe?

Our findings

People told us they felt safe and comfortable in the company of the staff who cared for them and nobody raised any concerns with us over their safety.

At the last inspection in September 2014 we identified call times were often erratic or missed which meant there was a risk to people's safety. During this inspection, we telephoned 18 people or their relatives and nine mentioned call times being a major concern. These people told us the reliability of the service had decreased recently, for example one person told us, "It's gone down the pan…it's getting poor since [new manager] came." We also visited 11 people in their homes. They or their relatives all told us they had some level of concern over visit times. For example, one person told us, "Sometimes they don't come for afternoon (visit) until 18.00 and evening not at all sometimes." The inconsistency of visit times posed risks to people's safety, as it meant they did not receive regular assistance with continence, mobility or medication.

During a home visit we saw one person received what the care worker described as a morning and lunchtime call merged into one at 10.50am. We saw this late call had impacted on their safety as the care worker told us prior to their arrival the person was wandering around the flat and had detached their continence aid. Daily records confirmed this was a regular occurrence for example, "[person] in a mess, convene leg bag unattached." Visits to this person were often late in January 2015 for example visits were recorded as over two hours after the planned time on 3,9,10,11,12, 15 & 16 January 2015 . Another relative told us they were concerned about their relative's safety as it was important that carers arrived at the same time each morning to prevent them wandering towards the stairs. Records we saw indicated visits to this person were over an hour late on two occasions between 1 and 11 January 2015. This showed us that inconsistent call times impacted on people's safety.

We identified a number of missed calls, for example one person told us there had been two missed visits between 1 and 11 January 2015. We looked at their daily records which showed gaps in the records for these days. Three other relatives told us about missed calls and records we saw showed gaps in the daily records indicating this was correct. In one person's records the relatives had written in the daily record "No carers yet again!" Our scrutiny of the daily care records for this person indicated that in a three month period there had been 20 occasions when carers had not attended. However, the manager pointed out to us that sometimes people will cancel a visit due to (say) a family social occasion, but the daily record made no mention of this. It was therefore not possible to clarify how many visits had been missed, although the above comments in the daily records indicated it was several. We asked the manager how many calls had been missed in December 2014 and January 2015 but they were not keeping a log of this information which posed a risk to people's safety if the extent of the problems were not known

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that where care staff handled money on behalf of a person, robust financial transaction records were kept. This demonstrated that the provider had appropriate procedures in place to protect people from financial abuse. We spoke with three members of care staff regarding safeguarding and whistleblowing. Our questions revealed that their knowledge was highly variable. We looked at training records which confirmed that only eight of 27 staff were up-to-date with safeguarding training which could explain the variable knowledge of staff members. This meant there was a risk safeguarding incidents would not be reported consistently due to variation in staff knowledge.

We judged that in some cases unsuitable and erratic call times constituted neglect of people who used the service. For example we looked at the daily records for one person who received support in getting up, going to bed and continence care. They had received their morning visit at 10.40 one day and the carers had left at 19.05, the previous evening. This meant they were in bed for nearly 16 hours, considerably more than the 11 hours specified in the original assessment by the local authority. For this person, on 10 occasions the gap between the evening call and next morning call was over 15 hours.This person was washed and their bed stripped each morning, indicating that they were left in a wet bed longer than necessary due to these timings. We visited another person one morning at 10.50am and they had just receiving their morning visit which documentation showed should have been at 8am. There was a strong smell of urine and the care support worker told us that they had become restless and spilt their

catheter bag. We also found a medication error, where a person had been given the wrong medication by a staff member who had not received medication training. We reported these three incidents as safeguarding incidents to the local authority.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw documentation was in place to report and investigate incidents. However, we found that no recent incidents had been documented or analysed. The manager told us one incident had occurred in December 2014, a medication error but they had not had chance to write it up. We saw that missed calls/late calls and medication omissions we identified through scrutinising daily records were not routinely reported as incidents through the incident management system. This meant risks to people's safety were not being regularly reported and analysed.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Risks to people's safety were highlighted on the personal support plan such as any underlying medication conditions. Risk assessments were in place which covered premises and moving and handling. However, most of these were out of date and required reviewing or did not contain a date which meant it could not be established when they were produced or whether they were relevant. For example, we looked at one person's manual handling assessment which had not been updated since October 2013. This stated they needed one staff member for assistance, however the person told us and records revealed that two staff now attended their evening calls due to their mobility problems. Not having up-to-date risk assessments means the risks to this person's safety had not been adequately evaluated.

During the inspection we looked at documents which were available to support the safe administration of medicines. We looked at Medication Administration Records (MAR). On many occasions this was not an accurate reflection of the prescribed medicine. For example, for one person we saw that hydrocortisone cream had been transcribed onto a MAR; there was no indication of where the cream was to be applied nor how much cream was to be applied. We saw that one person had been prescribed eye drops. The MAR recorded the frequency the drops had to be administered but gave no indication as to which eye the drops were to be instilled in. Another person had been prescribed an anti-emetic (for nausea). Whilst the MAR recorded the frequency of the medicine it did not indicate the dose to be given.

The MAR required care staff to record each time they supported people to take their medicines yet on many occasions there were gaps in signatures which meant there was no evidence these people received their medication. Where staff did sign, they were signing against the "dossett box" only which meant there was no process for checking and signing to confirm the administration of individual medicines.

We spoke with the manager and the provider about our findings. They told us they understood the inadequacies within the current MARs and were in discussion with a pharmacy to have the MAR prepared by the pharmacy at the time the dossett box was dispensed.

We visited one person in their home and saw they were supported with their medicines at each visit from a dossett box. However there was no MAR in their home, so staff were not keeping a record of the medicines given. This meant there was a risk of inappropriate care as it could not be confirmed whether this person had been supported with their medicines correctly.

We visited a second person who was receiving medication for the control of Parkinson's disease. These medicines must be taken at the prescribed times. Their action is short and they wear off. If someone does not have them at the time prescribed individually for them they may experience stiffening, increased tremor or inability to carry out tasks. We found call times were erratic, which meant this person received their medication at differing times, for example in the morning at 08.10 on 8 January and at 10.00 on 9 January and in the evenings at 18.00 on 20 December and 20.15 on 21 December 2014. This posed a risk to their safety and wellbeing. During the home visit to this person a care worker showed us that one medicine was kept in the fridge. However, there was no record of this on the MAR chart nor was it mentioned within the personal support plan. The care worker told us that they were unsure that other staff knew about this medicine due to its location in the fridge and the lack of records to indicate its presence. This meant there a high chance this medicine was not consistently administered.

Inadequate

Is the service safe?

The provider did not hold complete records of the medicines each person was supported with. This meant that there was a wider risk that time specific medicines were given at incorrect times. This was especially a risk given the erratic nature of visit times with some visits occurring less than two hours apart and the trend for visits to be squeezed towards the middle of the day.

One staff member raised concerns with us that a member of staff had made a medication error on 18 January 2015 and given the person's evening doses of medication in the morning. We spoke with the person who confirmed this was the case and told us they had been ill although they were not sure if it was a result of the medication error. We asked the manager about this, who confirmed the error had taken place and that this staff member had not received training in medication. We spoke with the staff member who confirmed the above. This showed us that staff were not always administering medication correctly, demonstrating inappropriate care.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that the provider had a recruitment and retention policy which was designed to ensure the service recruited suitable people to care for vulnerable adults. Scrutiny of three staff files provided evidence to suggest that the policy was not always adhered to. Three staff members also raised concerns with us that new staff were starting work before their Disclosure and Barring Service (DBS) or references were returned. In one person's file who had recently started work, we found that no references had been obtained from the previous employer. In another person's file we saw that they had started work 33 days before their DBS check had been returned. There was no evidence of an adult first check, or risk assessment detailing the control measures in place whilst the full DBS check was pending.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At the last inspection we found there were inadequate staffing levels to ensure safe care. We found staffing was still unsafe at the current inspection. A number of staff had left since the last inspection, and although the provider was in the process of recruiting staff, it was by its own admission struggling to cope. Following the inspection, the provider contacted the local council to withdraw from the Keighley area. The manager told us they, "Can't staff Keighley." The erratic call times and late calls times we noted in people's daily records, missed calls and people's feedback regarding call times confirmed to us that there were insufficient staff to meet people's assessed needs. The fact that calls were not on the rota at the times that met people's assessed needs confirmed this; for example, one person's bedtime call was on the rota at 17.45 w/c 6th January, when they told us they wanted to go to bed much later. Another person was the last morning call on one day's rota at 10.00 despite their care plan indicating an agreed time of 08.00. There was no travel time accounted for on the rotas we looked at, and a cramming of calls together. For example we looked at the rota for Thursday 15 January and saw that 6 calls were placed in a row directly after each other with no travel time. This showed there were insufficient staff to meet people's individual needs.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked staff if they knew of any agreed procedures to be followed in case of emergency. Staff were not able to make reference to written guidance. We saw there was a "no reply" policy in place which had been recently updated, and discussed at a recent meeting, but there was no evidence staff had signed to indicate an understanding of the policy and the above comments confirm this. However staff were able to describe effective actions for calling for an ambulance and were able to tell us in which circumstances they would inform management of untoward incidents.

At the last inspection in September 2014 we found occurrences where double up calls were not always attended to by two care workers. We found improvements had been made to this aspect of care with all double up calls attended to by two care workers. This was confirmed by people we spoke with which helped to ensure people were safe during moving and handling tasks.

Inadequate

Is the service effective?

Our findings

People we spoke with provided a mixed response about the quality of care provider by Dignicare. For example, one relative told us, "I'm extremely happy…her quality of life is as good as it can be because of the care they provide….they do a remarkable job in difficult circumstances…I'm absolutely satisfied with the care given." Another person told us, "The people who come are fine but it's the timing that's hopeless...our regular person gets on very well with her, she stays for the right time with no rush…when they come they are very, very good."

However, seven people or their relatives told us staff did not always have the correct skills or knowledge to care for them. For example, one person told us, "I have to tell them to empty the commode". Another person told us, "Sometimes a bit incompetent" and another person said, "New staff don't have a clue, they improvise." One relative told us that a new care staff had arrived late one morning and didn't know what to do, so they had to instruct them over the phone in order for medication support to be provided correctly. Another relative told us, "Staff are not trained in how to deal with people with dementia, can't trust Dignicare when I am not here." This showed inconsistencies in the knowledge and skills of staff.

We found care plans in people's homes did not always contain accurate instructions of the care required as they were not up-to-date or pages were missing. This meant staff unfamiliar with people's care routine did not have appropriate guidance to follow to ensure they completed the tasks correctly.

Two staff members raised concerns with us that new staff were sent out without the appropriate training. We found one member of staff who had not worked in care previously, had been administering medicines, resulting in an error before they had been trained in medication. The manager told us that new staff always shadowed and didn't give medication out until they had received their induction training, but the above incident indicated this system had failed.

We spoke with staff about their ability to access training. Staff told us that training was available yet they felt some areas of training were not up-to-date. One member of staff made reference to the need to update on moving and handling which the manager told us was proving difficult to arrange. Our discussion with staff regarding their knowledge of safeguarding and other areas of protective legislation showed that these areas of training required attention also. We looked at the provider's training matrix which displayed the completion of mandatory training. This showed staff were overdue training updates. For example, only 8 out of 27 staff had completed safeguarding training, and 11 out of 27 were up-to-date with medicines training and 7 out of 27 had completed Mental Capacity Act training. Practical manual handling training had been provided to some new staff as part of induction but only 4 out of 27 staff were up-to-date. One person told us that staff did not know how to use their hoist correctly; staff had thought it was broken and reported it as a fault, when in fact the emergency stop button had been pressed. This showed to us the impact of staff not being appropriately trained in manual handling.

During a home visit to one person, a staff member raised a concern with us that other staff did not always fit a Conveen sheath and night bag to the person and used pads instead as staff didn't have the correct skills. We examined this person's daily records on 31 December 2014 it was recorded "Couldn't attach nightbag as plastic bit missing." This was the only night that week that the night bag was not successfully attached, and records showed on this occasion the two staff in attendance, one was on their first day of work and the other had been working at the provider just 15 days. Their staff files contained no training documents and the training matrix failed to show they were up-to-date with mandatory training. On the 1st January 2015 it was recorded 'Pad put on as couldn't fit convene (sic) on right' and staff had also failed to attach the Conveen on the evening of 11 January 2015. This showed staff did not have the correct skills and knowledge to ensure appropriate care.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw staff were provided with periodic supervision where their performance was discussed. This included their attitude and any problems which arose in their work. Scrutiny of staff files showed that supervision and appraisals was a common but irregular feature of the service. However, two newly appointed senior care workers told us that they had a responsibility to provider supervision and carry out appraisals and they had the intention of doing so.

Inadequate

Is the service effective?

Support plans focused on people's activities such as choices regarding going to sleep or watching TV. People reported staff gave them choices such as what they wanted to eat. Where people were provided with support with their food, instructions were provided to assist staff. This included whether they needed their food cutting up and promoted choice. People reported that staff prepared the food they wanted at each meal.

However, we found visit times to people were not always conducive to appropriate support with food and drink. Three people told us that meals were often provided at inappropriate times due to the erratic nature of call times. We looked at these people's records which confirmed this was the case. For example, one person's records showed they were on occasions prepared breakfast and lunch just over an hour apart. For example, on four days in January, the morning call ended between 10.00 and 10.10 and the lunch call commenced at 11.20. They told us they were often not hungry at this time. In another person's records we saw their tea time call varied between 15.00 and 17.00. They told us that 15.00 was too early for their tea. During one home visit on 16 January we saw that breakfast and lunch were provided half an hour apart between 10.50 and 11.20. The staff member told us that they would have to merge the breakfast and lunch visit as they were so late. This showed that these people's mealtime needs were not always being met.

We saw no evidence of formal mental capacity assessments being conducted despite some people having a diagnosis which could impair mental functionality. For example, we saw the provider had recently verbally asked people and /or their relatives if they were happy with their call times. However, where relatives were asked it was unclear whether people had capacity to make these decision themselves as their capacity had not been assessed. Where relatives had consented, there was no evidence this was part of a best interest decision considering the health, safety and welfare impacts of changes to call times.

We also found an example of a recent consent process for asking people about their preferred call times was not undertaken correctly. A staff member told us how they had asked the person if they were happy with a bedtime call time of 18.00 as they were first on the rota. The person refused and the care worker then asked if 19.00 was okay, to which they hesitantly agreed. However, this was not an open question asking people what their preferred call time was. When we looked at the signed consent form, it was stated a preferred call time of 6pm – 7pm, and we found that call times were still occurring at 18.00, for example on 13 January 2015. When we spoke with the person they said their preferred bed time was 7.30pm to 8pm, indicating that valid consent had not been sought. In the majority of people's care plans we looked at there was nothing which stated they had signed to agree to call times which were different to those originally agreed, or that a discussion of call times and its effect on the provision of effective care had been undertaken.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People reported that staff asked them about their healthcare needs. Daily records provided evidence that carers queried any health concerns with management and then these were passed on to the relevant medication professional. For example, we saw that one person with complex care needs had been referred for a physiotherapy assessment. We saw that the care plan indicated a change in care provision as a result of the assessment. Daily care records showed that the new plan was been put into practice. This demonstrated the provider was ensuring that advice from health care professionals was being translated into appropriate care.

Call times were not conducive to providing effective healthcare to people. We found several examples where people's morning calls were significantly earlier and evening calls were later than agreed in people's plans of cares. This particularly impacted on people who relied on staff to put them to bed and get them up in the morning. It meant that key healthcare needs such as continence, skin care and medication were not always met by staff. For example, on scrutinising daily records, one person who required evening and morning continence care was on 10 occasions between November and January left for over 15 hours in bed. This meant there was an increased risk of skin integrity problems associated with a lack of continence care.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Is the service caring?

Our findings

People spoke positively about care workers attitudes and said they were treated with dignity and respect, but that call times let the organisation down. For example, one person said, "The people who come are fine but it's the timing that's hopeless." Another person told us, "They're really, really good with her… nothing's too much trouble. Mum really likes them…they're all women and they do a very good job." A third relative told us, "She is absolutely excellent, particularly if Mum's ill or we've a problem."

Some people indicated that care staff were sometimes in a rush, for example one person told us, "Mum gets on well with them all, they have a bit of a laugh with her and she feels safe, but I think they're a bit scruffy with the housekeeping, leave things on the floor and they're in and out quick." Another person told us, "They empty the commode as I can't reach it and they come in and make me a drink, but then if they ask me what else I can't think as they're in a rush and only stay five minutes…if I could just have a few minutes more I could think what they should do." We analysed some call times in people's daily records and found staff did not always stay for the agreed amount of time. For example, one person's morning call was contracted an hour in length but the average visit time between November and January was 37 minutes indicating some care staff were rushing. The lack of travel time built into some rotas may increase the pressure on staff to reduce the time spent on care tasks.

People and their carers consistently told us that although carers were pleasant there was no familiarity with different carers. For example, one person told us, "I think it's rubbish…it's inconsistent…I've been keeping a record as the times they come are inconsistent and there's been so many changes of staff". Another person told us, "[one morning] One carer told me they would be back at lunch but it was a different one, lots of different ones, would prefer same." A relative told us that they thought the lack of familiarity of carers impacted on the welfare of their relative who was confused and had dementia. People told us they would prefer care workers who they were familiar with and who were familiar with their needs.

Through talking with people and their relatives, we concluded that individual staff members were kind and compassionate and most people cited that as the best thing about the provider. However, we concluded that the service was not caring due to the erratic nature of call times, which caused people a lot of upset and worry. Call times did not reflect an organisation which respected people, for example one person's morning calls began at 7.30am for four days in a row and then switched to after 10am. We spoke with the person's relative who thought the calls should be around 8am in the morning and were not aware that they were often after 10am.

People told us that they were never informed if staff were going to be late and this left them wondering when staff would arrive. One person told us that they had to ring the office chasing calls and were often given excuses. There were re-occurring occasions in eight records we examined to put people to bed earlier and/or get them up later, than the agreement in their care plans, indicating that the service was not caring and was not providing individualise care which met people's needs.

Plans confirmed people's preferences had been sought, which indicated that people's had been asked for their views, choices and preferences .Person support plans focused on areas people were independent and could do tasks for themselves, such as washing their upper body. Plans considered dignity and giving people choice during the provision of care. However, as most care plans were out of date, it was not always clear whether these care plans still reflected people's current needs.

We looked at six care plans which showed that people had some input into their care plans. For example, we saw a personal support plan which had recently been reviewed. The plan was signed by the person receiving care and the staff carrying out the assessment. We also saw a moving and handling assessment sign by the person receiving care. However, other care plans were out of date and had not been regularly reviewed. The provider and manager told us that they were behind with reviews.

Five people told us that they felt their concerns and comments were not always listened to. For example, one person told us they did not want one care worker anymore as they made them feel uncomfortable, and received assurances from the senior care worker that they wouldn't be sent again, but they had arrived the next day which had caused them distress. People told us that staff did not always listen to them about visit times. For example, one person said, "I have complained several times about going to bed at 18.00, but nothing has been done". This showed the provider did not consistently listen to people's views.

Is the service responsive?

Our findings

A process was in place to assess people's needs before they started using the service. We asked a senior care worker how people were assessed prior to commencing care who described the process. The senior care worker would make an assessment of dependency which would lead to determining the level of staff input to each visit. We were further told that at the initial assessment, in the person's home, an environmental risk assessment was conducted to ensure care could be delivered safely both for the person and the staff. We looked at paperwork for new people who confirmed this took place and appropriate risk assessments and plans of care were in place.

However, the manager told us they had not yet had time to ensure current people's assessments were up-to-date and reflected their current needs. Five of the six support plans we looked out during our visit to the office were overdue their review date, some over a year out of date. Furthermore some care planning assessments were misleading. For example, one person's assessed need was to provide personal hygiene and continence care. The person was described as being doubly incontinent. When we mentioned this to the manager and owner we were told the person had a supra-pubic catheter yet no mention of this was made in the care plan.

Documentation in people's home's was also out-of-date, out of the 11 people we visited only one had an up-to-date personal support plan and one person's care plan had not been reviewed since 2012. Three people did not have copies of personal support plans in their home and three people had pages missing meaning there was a lack of accurate information for people to follow. Other documentation (such as risk assessments) did not have dates on it so it was not possible to determine whether it was still relevant.

One relative told us they had written their own care notes for staff as the current care plans were, "Rubbish." Discussions with and about more experienced staff implied that care was delivered based upon what the carer knew of the person they were caring for rather than the paperwork as it was not up-to-date. The feedback from people and their relatives was that new staff did not always know how to deliver appropriate care, and we judged the lack of appropriate care documentation contributed to this.

All care files were chaotic with care notes and other documents loosely placed in an open folder. Documents were not filed in any semblance of order and were commonly not named. This could easily mean that loose paper could migrate from one care file to another. The manager and provider admitted that paperwork was out of date and did not always reflect people's current needs. We saw evidence that the provider had begun to work through paperwork and had arranged some reviews but the majority of care assessments needed updating.

Daily records of care delivery were lacking detail in that they did not always indicate that the full range of care tasks had been completed, for example the continence care delivered was not always detailed. This meant there was a lack of evidence that staff had been performing the required care tasks.

We saw unexplained gaps in people's daily records through conversations with people and their relatives we concluded some of these were due to missed calls but often staff were not always documenting visits. One relative raised concerns with us that care visits were not always documented, they told us when they raised this with a member of staff they said, "Nobody ever reads it [anyway]."

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People did not receive care in line with their assessed needs. We found problems with call times to all 11 of the people we visited, either calls were too early, too late or erratic. Staff commonly arrived either later or earlier than the agreed times. For seven people we looked at who required support getting up and going to bed, call times were on average later in the morning and/or earlier in the evening that stated in their care plan meaning they were in bed for significant periods more than agreed in the original assessment. This was confirmed by people's comments. One person's relative told us, "It's gone a bit downhill since November…they're getting her out of bed later…originally she was got up at 8.00-8.30, now it's 9.30-10.00…if she's got up at 10.00 and then the dinner call is at 11.30 it's too early...then she's put to bed at 19.30 so that's too long in bed." Another person told us, "We were settled into a nice routine with no complaints until the new manager came…the rotas have been changed and there has been

Is the service responsive?

an increase in the turnover of staff, with different people arriving…the visits are erratic on timing, they used to come tennish and we understand delays of up to 40 minutes, but today she came at 11.30 to get her washed and dressed."

Records we looked at verified these concerns. We looked at 50 consecutive visits to one person. On 21 occurrences the visit was later than prescribed and in nine cases too early. The significance of this was that the evening visit was usually early and the morning visit late, thus lengthening the period they were left in bed during the night by up to two hours. Records showed another person was regularly receiving their evening call at around 18.30 but their assessment stated 20.30 as the assessed time, meaning they were receiving care two hours early and consequently left in bed for extended periods. Another person's personal support plan indicated a morning call of 08.00, however daily records indicated it was often much later than this, for example at or after 10.00 on nine out of 30 days sampled. A care worker told us that the person was more likely to detach their catheter leg bag if staff were late and we saw evidence of this in their daily records. Staff did not also assist this person with the correct continence aid for at least a 20 day period in November 2014, despite the provider having responsibility for ordering and managing the aid. The impact of this was often recorded in daily records with the bed being wet in the morning.

There was no consistency to call times which meant people received assistance with mobility, continence , medication and food at erratic times. For example, one relative we spoke with raised concerns about timings, we looked at the records which confirmed this ; they received their morning call at 8.05 one morning and 10.55 the next morning, and their evening call at 19.40 one evening, 20.00 the next evening and 21.30 the evening after. This inconsistency did not meet their assessed needs and was not conducive to effective continence management. Some people complained about visits not being appropriately spaced. We looked at records which confirmed this. For example, we saw one person had a teatime call which ended at 17.15, and the care worker for the evening call then arrived at 17.40. Another person's morning carer left at 9.00 and the late morning carer arrived at 09.15. These inappropriate gaps were not conducive to appropriate personal care.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Four people or their relatives told us they were very happy with the call times. Two of these relatives said that they were very happy with visit times as they had been moved to an earlier time to suit their relative's needs.

We asked to see the provider's records of complaints, the provider told us that two people had complained via email. We saw the provider had responded to these emails in a timely fashion. However, there was no central collation of complaints. As such we found it difficult to establish if this was the true number as they were stored only as emails within the provider's inbox. It was clear that verbal complaints received over the telephone were not logged as a number of people told us they had complained about call times, and late calls/missed calls but there was no log of these in the office. Feedback from people was that appropriate action on these issues had not always been taken by the provider. Given 9 out of 18 people we telephoned were unhappy and 11 of the 11 people or their relatives we visited raised concerns we concluded that the service had not taken effective steps to document and address concerns. Some people told us the office staff were not helpful and they didn't feel listened to. For example, one person said, "[manager] was supposed to see me on Tuesday then Thursday and she never turned up and never rang back." Another person told us, "We're thinking of changing as we need to up the care package and we're not entirely happy…there's been a lot of different girls. We've complained but it hasn't improved." This showed us that an effective system was not in place to deal with people's complaints.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Is the service well-led?

Our findings

The provider did not have a registered manager in place, the last manager deregistering in December 2014. A new manager had been employed and the Commission had recently received an application for the registered manager position.

People's views on the quality of management were mixed. One person told us they had been promised a meeting to discuss their concerns but this had not materialised, and they also told us, "The best carers leave, problems at the top." Another person told us, "Management is horrendous they were supposed to see us." Another third person told us the manager was rude to them when they had rung up to complain about call times. Another person said they thought the provider had been helpful but they had not as yet fully addressed their concerns.

We concluded that the provider had not provided us with information consistent with the records we viewed. For example, we were told that staff who had not completed induction training were not authorised to attend calls alone. However rotas and daily records indicated that one new staff member who the manager told us had not attended calls alone had done. The staff members and other staff's testimony confirmed to us they had attended calls alone.

Two staff we spoke with said improvements were underway but had not yet been fully achieved. For example one staff member told us, "We are making considerable improvements on the past service but it will take time," and, "We will be able to ensure we visit on time when we have a few more staff, staffing levels are improving and will be sufficient when the recruitment process is complete. Since [manager] and [owner] have taken over things are looking up. Communications are much better. We have better staff now; the poor ones have gone." However two other staff told us that things had got worse recently with staff leaving and chaotic rota planning. We saw the provider and new manager had begun meeting with people to introduce the new management arrangements and discuss their plans of care but we found this process still had a long way to go before all concerns had been addressed and care reviews were up-to-date.

At the last inspection we found quality assurance systems were inappropriate to monitor the quality of the care provision and we found this was still the case. We found that some spot checks on care quality had taken place between November and January, with records indicating that most people described the care as good and no problems were recorded. We also saw documentation had been created indicating people had been asked about their preferred call times, and most people on the list stated they were happy with the times. However this information did not correlate with our findings that a significant proportion of people were spoke with were unhappy with call times. This indicated the provider's system for gaining and evaluating feedback was not effective in identifying people's concerns.

We found that although there were some examples of high quality care provided, this was inconsistent and dependent on the staff member on duty. Seven people or their relatives raised concerns about the skills of new or unfamiliar staff and we found the provision of training to staff was inconsistent. This was confirmed in the records we looked at, with inconsistent record keeping for example around care delivered and medication administered dependant on the staff on duty. The inconsistency in the quality of staff performance should have been identified and rectified through an effective programme of quality assurance.

Although care plan reviews had been begun, these had not been completed, the action plan submitted to us following the September 2014 inspection stated they would be completed by 26 November. However most care plans we looked at were out of date and three people also complained to us that they had not received a regular review. Other points we raised in the September 2014 inspection had also not been addressed. For example , we raised concerns about the impact of call times on one person, however the provider had not looked into these concerns or conducted a care plan review. This meant there was a risk of inappropriate care as care quality concerns raised with the provider were not promptly addressed.

In the action plan submitted to us in September 2014, the provider stated they would be auditing records to ensure that call times were suitable. We found that the office manager had signed records to indicate they had been checked, but records that had been signed off as checked included those with call entries not recorded and inconsistent and unacceptable call times. There was no

Is the service well-led?

analysis of these call times to determine the performance of the organisation or whether the provider had enough staff to deliver calls in line with people's assessed needs. This put people at risk of receiving inappropriate care.

We asked the manager how many missed calls had taken place in December 2014 and January 2015 but they were unable to provide us with this information. Some people told us calls had been missed and our scrutiny of dally records revealed that a number of calls were missed and others were not documented by staff. There was no system in place to promptly identify missed calls, or reliably provide information on the extent of the problem. Communication of missed calls relied on the person complaining to the provider. This put people at risk of inappropriate care, particularly if they were not able to verbally communicate with the provider.

The manager was unaware of quality issues we pointed out to them on looking through daily records such as "person soaked through due to early call". This meant the care performance of the organisation was not being robustly monitored. There was no consistent system to bring care records back to the office such as daily records and MARs for regular checks, we found some old records still remained in people's houses and the management of data was chaotic in the office making it very difficult to locate records from a particular period of time for analysis.

No audits into care records or medication were undertaken. We found significant shortfalls in the quality of the care records and the medicines management system.

An incident management system was in place although we found some incidents had not yet been written up, for example an incident from December 2014 had yet to be documented. We found that missed or late calls or medication errors were not being routinely documented and investigated as part of a robust system to analysis and learn from incidents.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was evidence that periodic staff meetings took place, which discussed new policies and procedures, communication, double ups, call times and the new non-response policy.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Service users were not protected against the risks of unsafe care as a through assessments of people's needs was not always carried out. Planning and delivery of care did not always meet people's individual needs or ensure the welfare and safety of the service user.

The enforcement action we took:
CQC is considering the appropriate regulatory response to resolve the problems we found

Regulated activity	Regulation
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person had not protected service users against the risks of inappropriate or unsafe care and treatment as effective systems to regularly assess and monitor the quality of the service provision were not in place.

The enforcement action we took:
CQC is considering the appropriate regulatory response to resolve the problems we found

Regulated activity	Regulation
Personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person had not protected people against the risks associated with the unsafe use and management of medicines because the provider did not have appropriate arrangements for the recording and administering of medicines.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
CQC is considering the appropriate regulatory response to resolve the problems we found

Regulated activity	Regulation
Personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity had received appropriate training.

The enforcement action we took:
CQC is considering the appropriate regulatory response to resolve the problems we found

Regulated activity	Regulation
Personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered person had not ensured that service users were protected against the risks of inappropriate care and treatment arising from a lack of proper information as an accurate record in respect of each service user was not always kept.

The enforcement action we took:
CQC is considering the appropriate regulatory response to resolve the problems we found

Regulated activity	Regulation
Personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse People were not safeguarded against the risks of abuse as the provider had not taken sufficient action to protect people from neglect.

The enforcement action we took:
CQC is considering the appropriate regulatory response to resolve the problems we found

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered person had not ensured that effective recruitment procedures were in place to ensure people employed were of good character. Information specified in Schedule 3 (references and DBS checks) was not available in respect of a person employed for the purposes of carrying on the regulated activity.

The enforcement action we took:
CQC is considering the appropriate regulatory response to resolve the problems we found

Regulated activity	Regulation
Personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person had not taken steps to safeguard the health, safety and welfare of service users at all times ensuring there were sufficient numbers of suitably qualified, skilled and experience staff on duty.

The enforcement action we took:
CQC is considering the appropriate regulatory response to resolve the problems we found

Regulated activity	Regulation
Personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for the obtaining, and acting in accordance with, the consent of service users in relation to the care provided to them.

The enforcement action we took:
CQC is considering the appropriate regulatory response to resolve the problems we found

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Personal care

Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints

For the purposes of assessing and preventing or reducing the impact of unsafe or inappropriate care, the registered person had not put in place an effective system for identifying, receiving , handling and responding appropriately to complaints and comments made by service users or those acting on their behalf.

The enforcement action we took:
CQC is considering the appropriate regulatory response to resolve the problems we found