Regional Care Services Limited

Carewatch (Hampshire South)

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?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

The inspection was announced and took place over three days, on 14, 15 and 16 September 2015. We inspected at this time because we had received a number of concerns about the care provided. We gave the provider 48 hours' notice to give them time to become available for the inspection.

The service did not have a registered manager. A new manager had started on the second day of our inspection and advised us it was their intention to apply to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

Carewatch (Hampshire South) provides care to people living in their own homes across various locations in and around the Hampshire area. The exact number of people cared for by Carewatch was difficult to ascertain due to the high number of hours not being provided and care packages being handed back by Carewatch to the local authorities. The interim senior branch manager and the quality manager told us Carewatch provided care and support to 543 people.

At this inspection we found widespread shortfalls in all areas we looked at. In April 2015 the provider merged two of their offices and all its care provision into one location. Staff, relatives, healthcare professionals and people using the service consistently told us this had a significantly negative impact on the organisation, coordination and care people received.

The provider did not have enough suitably, skilled, qualified and experienced staff to meet people's needs. There were a significant number of missed care calls which put people at risk of not receiving the care and support they needed. People were often not being supported to take their medicines and not being supported with personal care.

Staff were not familiar with the providers safeguarding policy and some concerns were unreported.

People were not always treated with dignity and respect. People and relatives told us office staff were often rude and failed to return their calls.

Procedures for the recruitment of staff were not robust and potentially unsuitable staff were employed to provide care. Senior staff told us they were "guilty" of employing "unsuitable" staff.

People were not always supported to take their medicines safely. Staff, relatives and people told us documentation for the recording of medicines administered were not always in place. Staff were not always trained to administer medicines.

The induction of new staff and ongoing development was not robust and placed people at high risk of receiving inappropriate and unsafe care. Records showed significant gaps in staff training. Relatives, healthcare professionals and people told us they were not confident staff had the skills and knowledge to deliver effective care.

Staff were inadequately supported and supervised. Supervision, appraisal, competency assessments and spot checks were not consistently conducted. Staff told us they had not had supervision and on occasions told us they were unsure if they were performing effectively due to the lack of support and direction.

Decisions made in people's best interests were not assessed in line with the requirements of The Mental Capacity Act 2005. Assessments were generic and did not assess specific decisions taking account of possible risks, benefits, other options and possible consequences.

People who were at risk of malnutrition and dehydration were not always supported effectively. Staff told us the high number of missed calls resulted in some people going without food and drinks at the times they needed it. Nutritional care plans were not always detailed and assessments that were in place were not reviewed frequently.

People's care records were not personalised and did not reflect their actual needs and preferences. In some cases, care plans were not in place at all and staff told us records were not accurate due to the lack of reviews in people's care.

The service was not well-led and many staff told us they were frightened or didn't want to talk with us due to fear of being punished by senior members of staff. The culture of the service was chaotic, unorganised and lacked strong leadership and direction.

We found nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and we issued two warning notices.

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

You can see what action we told the provider to take at the back of this 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. The provider had significant shortfalls in respect of the number of suitably qualified, skilled and experienced staff.

The provider did not take all reasonable steps to ensure the recruitment of staff employed were of suitable character to care for vulnerable people. Staff were not knowledgeable about the providers safeguarding procedures and did not feel confident senior staff would act on any concerns raised.

People were at risk because appropriate arrangements were not in place to handle and administer medicines safely. Risks relating to the health, safety and welfare of people had not been properly assessed and responded to.

Is the service effective?

Inadequate

The service was not effective. Staff were not adequately trained or supported to deliver effective care. We identified significant and widespread shortfalls in respect staff induction and ongoing development.

People who were at risk of dehydration and malnutrition were not supported effectively.

Decisions made in people's best interest were not assessed in line with the requirements of the Mental Capacity Act 2005.

Is the service caring?

Inadequate

The service was not caring. People were not always treated with kindness, respect and dignity.

Care plans did not always contain useful information to help staff build positive relationships with people.

Is the service responsive?

Inadequate

The service was not responsive. Complaints were not always dealt with in a timely manner and people were not listened to when they expressed their views about the care they received.

Care plans did not always provide sufficient detail and guidance for staff to provide the support people needed.

Is the service well-led?

Inadequate

The service was not well-led. Leadership within the service was weak, inconsistent and not always transparent.

The absence of effective quality monitoring had a significant impact on the health, safety and welfare of people.

The culture of the service was poor. Staff were frightened to raise concerns due to fear from senior management.

Carewatch (Hampshire South)

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14, 15 and 16 September 2015 and was announced. We gave the provider 48 hours' notice to give them time to become available for the inspection.

The inspection team consisted of two 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.

Before our inspection we reviewed previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about by law. We had received information of concern from healthcare professionals, people and relatives which prompted us to carry out this inspection at this time.

During our visit we spoke with the interim senior branch manager, the quality manager, the recruitment manager; four care co-ordinators; six care workers and an administrator. We visited three people in their homes and met with four relatives. We spoke with the managing director and the regional operations director. We spoke with eight people and six healthcare professionals on the phone.

We pathway tracked nine people. This is when we follow a person's experience through the service and get their views on the care they receive. This allows us to gather and evaluate detailed information about the quality of care. We looked at staff duty rosters; records relating to missed care; incident records; safeguarding records and complaints. We also looked at staff recruitment files; staff induction and training records; quality assurance records and support; supervision and appraisal records and the provider's quality assurance audits.

Inadequate

Is the service safe?

Our findings

We received information of concern from healthcare professionals, relatives, people and whistle-blowers. They told us people were not being supported to manage their medicine safely and said the provider did not have good systems in place to assess and mitigate risks. We were advised there were not enough staff employed which resulted in people not being cared for safely. They said the recruitment and selection of new staff was not robust and told us the provider employed some unsuitable staff.

The provider had significant shortfalls in respect of the number of suitably qualified, skilled and experienced staff. One person told us they had a large amount of missed calls. They said: "I keep getting told by the office they have no staff and that's why they couldn't cover my call". A member of staff told us the service provided care to 543 people across various locations. They said: "We have 946 hours of care to deliver with only 500 hours of care staff to deliver it, we can't do it". Another member of staff told us the agency were using staff from other domiciliary care agencies to try and fill the gap, including permanent staff worked a lot of overtime. They said: "I did 102 hours overtime in a week on top of my 37.5 hours. They (Carewatch) just keep saying yes to take more and more people and so many are left without care it's dangerous". Another staff member said: "We are recruiting: two care co-ordinators. We have: four field care supervisor vacancies; 10 senior carer vacancies; one full time administrator vacancy and 10 assessor vacancies". Staff consistently told us the number of missed and late calls resulted from insufficient staffing levels had a significant impact on people's welfare and safety. A member of staff said: "Last weekend two of us were supposed to cover the on-call. We had to phone the manager to come in and do the on-call co-ordination, so we could go and deliver care. Four agency staff who were supposed to cover went off sick. We worked from 6.00am and finished at 10.20pm".

Carewatch monitoring records demonstrated the significant shortfall in staffing. Carewatch failed to provide care to one person on five occasions from 28 August 2015 to 30 August 2015 and failed again to provide care to another person on 13 occasions from 31 August 2015 to 04 September 2015. Missed and late care calls had a substantial impact on people's wellbeing. For example, one person required four care visits each day. Their relatives told us the person needed their continence pad to be changed during each visit, to be supported to take their medication and to be encouraged to eat and drink. On one occasion this person had not received care for a period of 26 hours and went without care. In one particular week the same person's care schedule revealed 11 different agency staff had delivered care to them. Their relative said: "Carewatch have never got the staff so they get agency in and they don't have a clue. 11 people in a week to look after someone with dementia is shocking, he needs familiar people and we need people we can trust, I am so angry". One person said: "I'm diabetic; I'm on insulin, which I give myself, but I need to know when [carers] are coming so I know when to prepare breakfast, as I have to have my insulin at a certain time before it. The time they come varies between 7.15 to 9.00am, and I can't have my breakfast until they come, so I don't know when I can give myself my insulin. Sometimes I'm really hungry because they are so late"

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider did not take all reasonable steps to ensure the recruitment of staff were of suitable character to care for vulnerable people. One member of staff said: "Sometimes we are guilty of employing unsuitable people" and "The team before was like a dysfunctional family with lots of people who shouldn't have been employed. We suspended seven staff at one point". Application forms were not always fully completed and staff employment histories had large gaps which were not explored at interview or recorded. Some references did not contain names and addresses of those who wrote them. A member of staff said: "Those references could have been written by anyone so we are not getting it right, it is awful really". The provider kept a record for staff who had received Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. We found that whilst staff had received DBS checks when they were employed, the provider also required staff to sign an annual declaration to confirm their suitability to work with vulnerable people. A number of staff had not completed the annual declaration. A staff file audit dated 7 September 2015 stated a member of staff declared they had a conviction. However, "No

Inadequate

Is the service safe?

evidence of risk assessment or statement on file" was identified. This demonstrated the agencies recruitment procedures were not being operated effectively and this put people using the service at unnecessary risk.

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

Staff were not knowledgeable about the agencies safeguarding procedures and did not feel confident senior staff would act on any concerns raised. 103 staff were listed on the agency's training record as having out of date safeguarding training. Staff were unable to tell us where they would find contact details for the local authority safeguarding team and the Care Quality Commission. A relative said: "My father has gone without care for a day; he was left in his own faeces, no food and on his own. Nobody from Carewatch told the local authority or the CQC, I had to do it. I worry about the people who don't have a voice".

Staff were not familiar with the whistleblowing policy and procedure. Whistleblowing is the term used when someone who works for an employer raises a concern about malpractice, risk (for example about people's safety), wrongdoing or possible illegality, which harms, or creates a risk of harm, to people who use the service, colleagues or the wider public. Staff are more likely to raise concerns at an early stage if the whistleblowing policy and procedures are clear and easy to use. Some staff said they were frightened to raise concerns with senior management. The systems in place did not operate effectively to ensure people were protected from harm.

This was a breach of Regulation 13 (1)(2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were at risk because appropriate arrangements were not in place to handle and administer medicines safely. A quality assurance audit dated 07 September 2015 concluded it was not clear from people's care plans as to who required support to manage their medicines. Staff told us they were not confident in helping people to manage their medicines. 71 staff had not updated their medication awareness training. People and relatives told us medication administration records (MAR) were not always in place and said staff had not consistently signed the MAR chart to show whether medicines had been taken or refused. We heard one member of staff in the agencies office say to another member of staff: "Don't worry about MAR, just write what he's had on a piece of paper". MAR charts viewed in people's homes confirmed administration of medicines were not always recorded.

We found significant shortfalls in how the risks relating to the health, safety and welfare of people had been assessed and reviewed. The providers "client reviews due" record showed a large amount of people had not had their care needs reviewed. For example, two people were due to have a "full assessment" on 9 August 2015 and four people were due "an initial review" on 18 August 2015. Staff told us these reviews did not happen. The document showed 18 care reviews were scheduled on 22 May 2015. Staff told us the reviews did not take place. A relative said: "These care plans and risk assessments are so out of date it's a joke. Some of the carers try but they aren't given the right information to help them do their job".

Staff told us these reviews did not take place. Staff consistently told us risk assessments were not detailed and said systems to mitigate risks were poor. A member of staff said: "Most of the risk assessments are rubbish, out of date or not in place at all". An assessment dated 28 February 2013 stated one person was at high risk of "slips and falls". Their care plan did not contain sufficient guidance to reduce the possibility of harm. A member of staff who provided support to them said: "I always feel like (person) is going to fall, I don't really know what I am doing because there is literally nothing in her care plan so I just hold on to them". Another member of staff said: "How are new staff meant to know what to do when they have no care plan or risk assessment to follow"? A relative told us they consistently had to tell staff about the risks involved when they provided care to their loved one. They said: "My (person) can't move, can't speak and can barely open their eyes. The risks have changed; the care plans here are all wrong and have never been reviewed".

This was a breach of Regulation 12 (2) and of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service effective?

Our findings

We received information of concern from healthcare professionals, relatives, people and whistle-blowers. They told us staff were not being inducted into their role effectively and said learning and development opportunities were not provided. We were advised staff were not being supervised properly and that people's nutrition and hydration needs were not being met.

The providers' website states: "We are committed to delivering exceptional training programs built to enable individual growth and success" and "our home care workers are highly trained, compassionate people who are proud to deliver a high quality home care service for the elderly. You can trust that you or your elderly relative will be in safe hands, receiving the support that is wanted, needed, and deserved".

Staff were not adequately trained to deliver effective care. We identified significant and widespread shortfalls in respect staff induction and ongoing development. One member of staff said: "We have staff ready to start; but no trainer because they've been sacked." Induction workbooks and "assessment of learning journals" used to support the development of new staff had substantial gaps. The workbooks were often unmarked and many pages were left blank with questions unanswered. A member of staff said: "We are meant to complete these books to help us learn about what we should be doing but nobody does, they never get checked or marked anyway". The staff concerned were actively providing care to people in their home without adequate induction or training. Those who had completed their induction training had covered all key health and safety subjects in two days. For example, day one covered: health safety and fire awareness; infection prevention; mental capacity act and DoLS; safeguarding; medication awareness; documentation and record keeping. Day two of the training covered: food safety, nutrition and hydration; dementia awareness; first aid awareness; moving and positioning. One member of staff said: "How on earth can anyone learn about all those subjects in two days? They are just trying to save money"

Carewatch provided a two day training course, 'back to basics' for established staff which. The course covered refresher training workshops where staff were trained in the same subjects covered during their induction. This meant staff could not spend much time learning about each topic. The training record indicated that 74 staff had not updated the 'back to basics' training on the due date. A member of staff told us their training was inadequate and said: "Moving and handling took 20 minutes, so I'm just using my previous experience! Medications training only lasted for one and a quarter hours".

The provider's 'supervision and appraisal policy', dated July 2015, stated, "all staff within the company must receive individual supervisions." Staff had not received regular supervision. Supervision and appraisals are important tools which help to ensure staff' receive the guidance required to develop their skills and understand their role and responsibilities. Prior to April 2015 records showed staff had received regular monthly or bi-monthly: supervisions; observations of practice; or spot checks, although records of these were not detailed and did not show discussions about learning and development. Records of staff supervision from April 2015 onward showed some staff had not received any supervisions or spot checks of practice.

Staff told us supervision had not been a priority since the merger of branches in 2015. A staff member told us, "Since April we haven't had time to do anything." Staff said the provider had made a number of senior grade staff redundant as part of the merger of the Southampton and Chandlers Ford branches. A staff member told us, "In the Southampton branch there were three co-ordinators and 12 care supervisors. There is now two care co-ordinators, and one is off sick. There are two care supervisors, but they are busy providing care. There are 77 care workers in Southampton. We used to have supervision every three months, but we haven't had any since the merger." Another staff member told us, "Care workers were made supervisors and not provided with any supervisor training." Another staff member told us, "We haven't been told how often we should supervise staff. We haven't got the time to do spot checks."

This was a breach Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People's nutritional needs were not being met. A care plan dated 28 February 2013 stated: "Inadequate food and drink intake" and were assessed as "high risk". Their care plan said: "monitor and record food and fluid intake". Records did not show staff consistently recorded intake. A member of staff told us the person's care plan was still accurate and said it had not been reviewed. A relative said: "We even

write care plans for the staff so they know what to make him for lunch and dinner but they don't even do that. (Person) is at risk of losing weight because they don't follow it". Training records showed the staff who provided care to this person had either not had training in nutrition and hydration or they required an update in their learning. A member of staff told us people were at serious risk of becoming unwell due to the high number of missed calls and the impact it had on their diet. They said: "If we miss a call it potentially means someone goes without their breakfast, lunch or dinner". Relatives confirmed their loved ones had gone without eating and drinking on occasions due to missed calls.

This was a breach of Regulation 14 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not act in accordance with the requirements of The Mental Capacity Act 2005 (MCA). The MCA contains five key principles that must be followed when assessing people's capacity to make decisions. Staff were not knowledgeable about the MCA and documentation did not show people's decisions to receive care were respected and agreed in their best interest. For example, the agency conducted an assessment for one person who had been diagnosed with dementia. Their capacity assessment dated 27 February 2013 showed consent was obtained to "carry out a needs assessment of me" and "carry out shadowing and spot checks for new care/support workers in my house". The capacity assessment also stated "any other" as part of it's questioning to gain consent. The providers' capacity assessments were generic and did not show the risks of particular decisions, benefits and alternative options had been considered. Documentation showed consent to provide care was authorised by the representation of a tick in their assessment. Capacity assessments were also not reviewed regularly.

This was a breach of Regulation 11(1)(2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service caring?

Our findings

We received information of concern from healthcare professionals, relatives, people and whistle-blowers. They told us people's privacy and dignity was not always being respected. We were told office staff were often unhelpful, rude and did not always respond to enquiries.

People were not always treated with kindness and respect. Relatives and people consistently told us it was difficult to make contact with office staff when making enquires about care visits. One person said: "It's the office that's chaotic – they don't care" and "They never get back to us, I have called loads of times. Sometimes the phone just rings for ages" and "They (office staff) sound annoyed at times when I phone them to ask where my carer is". A member of staff told us they were aware office staff did not always return calls to people. A healthcare professional said: "I have left a few messages in my time when dealing with Carewatch and they have not been responsive. It is poor". Whilst visiting the office we heard one member of staff say: "I will call you back in five minutes to let you know who is coming". We observed the member of staff working for a period of 20 minutes and found they did not return the call during this time. A member of staff said: "Six times I rang my co-ordinator, eventually I got a reply from a third party, but I could hear my co-ordinator in the background, so I knew she was there, and avoiding me".

People's dignity was not always maintained. Despite several conversations with senior staff, discussions with care coordinators and formal complaints made one person continued to receive care from a male care worker when they and their family had requested a female care worker. The relative told us their loved one under no circumstances wanted to receive personal care from a man. Their care schedule showed male care staff were still being sent to provide care. They said: "It's for (persons) dignity, (person) has always said they didn't want men and despite our continued request they still send men and even worse, they have sent male agency staff who we don't even know".

Care plans did not always contain useful information to help staff build positive relationships with people. Records were often incomplete providing limited information about people's likes, dislikes, hobbies and interests. One member of staff said: "In other places I have worked the care plans have information about people's history, like old jobs and stuff. I haven't seen any of that here". A relative told us they had to tell staff during each visit about their loved one. They said: "We have a few regular carers who know but I usually have to tell them about (person) because they have no idea". Another relative told us it was important staff knew about their loved ones past because (person) has dementia and discussions about previous jobs and holidays helped stimulate conversations. They said: "The inconsistency of staffing has resulted in a lack of knowledge and care".

This was a breach Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us they felt happy with their care staff and told us most of them did the best they could in the time they had. Comments included, "The care, as such, is first class – it took a bit of time, over a year, to establish a routine, but now we have devoted people who give excellent care" and "Brilliant – they're so good" and "They're a lovely set of girls". One person told us the care they received was better organised before the two offices merged into one. They said: "I used to get calls at the right times before but now they have changed their office it has gone wrong".

Inadequate

Is the service responsive?

Our findings

We received information of concern from healthcare professionals, relatives, people and whistle-blowers. They told us complaints were not being taken seriously and care plans were not always in place or accurate.

Complaints were not always dealt with in a timely manner and people were not always given opportunity to express their views about the care they received. Since May 2015 the provider's records showed they had received 106 complaints. Although we were able to see some recent progress in terms of the provider's response, a large number of complaints were yet to be acknowledged and investigated. People told us they often felt ignored. One person said: "Time and time again I ask when my carer is coming and I don't get an answer or a call back". A relative told us their loved one required two care workers to provide personal care. They said "There are meant to be two carers not one which means I have to help and I don't keep well myself". Records showed the relative had made several complaints about the lack of care staff, late calls and the high number of agency staff. They told us their complaints were not listened to. We visited the relative and their loved one and found only one member of staff attended the care visit. The relative said: "See, they don't listen or act on complaints, there is your evidence. One carer and it should be two". Other complaints not dealt with appropriately related to missed visits, concerns about confidentiality, care times being changed without consultation with people, care rotas not being sent to people and early calls.

This was a breach of Regulation 16 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities (Regulations 2014)

Care plans did not always provide sufficient detail and guidance for staff to provide care. Information about nutrition and hydration; skin breakdown; continence care; showering and shaving was not always included. A care plan for one person who required continence care and assistance to shower did not provide guidance about how staff should assist people to meet their needs. Staff often told us they were confused about the care they needed to provide due to insufficient care planning and poor communication. A member of staff said: "There are people getting care from us who have no care plans at all in place". Relatives told us the care plans didn't help staff as they did not reflect their loved ones needs. One relative said: "It doesn't tell staff to change his pad, feed him and get him a drink. I have to leave notes out for the staff so they know what they have to do".

People who were living with dementia did not have best practice guidance in their care plans and information about behaviours that may have challenged others were not recorded. One member of staff said: "We have our usual clients to look after so we know more about them but sometimes we have to have a bit of a guess at what we need to do with others we don't know". Another member of staff said: "I had to call an ambulance once whilst I was with a client, and I've never been so ashamed – there was so little in the client's log, that I couldn't tell the paramedics anything about the person's condition; I had to say I didn't know anything, and ended up ringing the office, handed my phone to the paramedic, and they told him from her records." Care records we looked at in people's homes were out of date, not accurate and unused. For example, one person living with dementia had no record of their condition in their care plan. Their relative said: "How an agency member of staff could support (person) with dementia without any information is a joke".

This was a breach Regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service well-led?

Our findings

We received information of concern from healthcare professionals, relatives, people and whistle-blowers. They told us senior management were not approachable and that issues raised were not listened to. They said the culture of the service was poor.

The absence of effective quality monitoring had a significant impact on the health, safety and welfare of people. Systems and processes to mitigate risk and drive improvement were not always applied, evaluated and acted upon. For example, staff were not appropriately trained to provide support when helping people with their medicines; they were not trained effectively to deliver safe moving and handling techniques. Care plans and risk assessments were not regularly assessed, reviewed and updated. Significant shortfalls in the number of staff employed resulted in a substantial amount of missed care calls leaving people without care. Recruitment processes were not robust and allowed potentially unsuitable staff to care for vulnerable people.

The provider conducted an audit on 7 September 2015 and asked a total of 161 questions to assess "internal compliance". The quality manager told us they had been brought in to "fight fires", deal with complaints, safeguarding concerns and to drive improvement. The report found 70 questions were "met" with 91 "unmet" representing 43% compliance. A member of staff told us the result of their audit was shocking and very upsetting. Another member of staff said: "I am not surprised given the amount of problems we have had since we merged the two offices. Almost everything that could go wrong has gone wrong". The managing director told us he was aware Carewatch (Hampshire South) were struggling to manage the care contract they had with Hampshire County Council in April 2015. He told us the provider transferred an interim senior branch manager and a quality manager to help drive improvement. He said: "We are failing people, this framework is failing". Although we have seen some areas of improvements such dealing with recent complaints effectively, not enough action had been taken to keep people safe.

The providers staffing and management structure was unclear and staff were unsure of their responsibilities. Many staff told us since the merger of the two offices some of them had not been issued with their contracts. They said they had not been provided with an updated job description. Comments from a group meeting we participated in included, "We don't know who is meant to be doing what because everything has changed" and "We haven't had time to do anything whatsoever" and "We are just running around like headless chickens fighting fires and dealing with complaints, missed calls and safeguarding left right and centre".

Leadership within the service was inconsistent and not always transparent. A member of staff said: "We get no help from Head Office. The interim manager asked the director to come in. He didn't turn up. We've asked for loads of meetings. We have been told not to phone Hampshire (Hampshire County Council) because CQC will get involved". Three members of staff told us they couldn't speak to us on their own due to worries they would be "punished" by senior management. Some staff told us they had faith and confidence in their line managers whilst others told us their request for support to improve the service was ignored. One member of staff said: "I have asked for help time and time again and they don't listen". Another member of staff said: "Apart from (member of staff) and (member of staff) nobody higher up is interested, they don't bother coming down and it's not acceptable". The local authority told us they were not always provided with a good response from the provider and said cooperation to help drive improvement was not always effective.

This was a breach Regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Some staff were positive about their line manager and said: "The interim operations manager is fantastic. She is very supportive. She's gone out and done care." And "We have a weekly co-ordinators meeting with the interim manager. She does listen. She will give 1-2-1. She will come and meet us outside work hours. If she goes we will all go. We learn from her. She sits down and shows us" and "If we knew the interim manager was going to stay we would work really hard to support her."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The provider did not have a sufficient number of qualified, competent, skilled and experienced staff deployed. Staff did not receive appropriate support, training, professional development, supervision and appraisal.**

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not appropriately assess the health and safety of people and did not take reasonable steps to mitigate risks. Staff were not appropriately qualified to meet people's needs.**

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have robust arrangements in place to monitor, assess, evaluate and improve the quality of care people received.**

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The provider did not have robust arrangements in place to check staff were of good character or that they had suitable qualifications, competence, skills and experience necessary to care for people effectively.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The provider did not have suitable systems and processes in place to investigate and act on any allegation of abuse.**

Regulated activity	Regulation
	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider did not act in accordance with the Mental Capacity Act 2005.**

Regulated activity	Regulation
	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The provider did not have appropriate arrangements in place to meet people's nutritional and hydration needs.**

Regulated activity	Regulation
Personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People were not always treated with dignity and respect.**

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The provider did not have effective systems in place for identifying, receiving and handling complaints.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have robust arrangements in place to regularly assess and monitor the quality of care people received.

The enforcement action we took:
We issued a warning notice in relation to this regulation

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not have a sufficient number of suitably skilled, qualified and experienced staff employed to meet people's needs.

The enforcement action we took:
We issued a warning notice in relation to this regulation