CompKey Healthcare Ltd

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Inspection report

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Date of inspection visit:
19 November 2018

Date of publication:
18 January 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection visit took place on 19th November 2018 and was announced.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. At the time of the inspection around 30 people were using the service.

There was a registered manager working at the service. 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. The registered manager at this service was also the provider and will be referred to as such throughout this report.

At the last inspection of this service, we rated the service overall as requires improvement. This was because people had not received good quality care and risks to their safety had not been managed well. This resulted in the provider being in breach of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following that inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the quality of care to at least good. At this inspection we found that the required improvements had not been made. The provider continued to be in breach of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one regulation of the Care Quality Commission Registration Regulations 2009. Therefore, the overall rating for the service is now inadequate and the service in 'special measures'.

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

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

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

inadequate for any of the five key questions it will no longer be in special measures.

The provider had continued to fail to ensure that robust governance systems were in place to monitor the quality and safety of care people received. Due to these poor systems, the provider could not be assured that people had received their medicines correctly. Also, people had been exposed to risks to their safety which had resulted either in actual harm or risk of harm.

Analysis of incidents, accidents and concerns raised had not taken place to promote a learning culture. CQC had not been notified of some incidents that we are required to be notified by law. Where we had been notified, this had not been completed in a timely manner.

The provider had not ensured there were enough care staff working for the service to cover the care visits required. This has resulted in office staff consistently covering these visits which impacted on their ability to monitor the quality of care being given to people.

Not all staff had received the appropriate training or supervision before they performed certain tasks such as giving people their medicines which put people at risk of unsafe care.

Care had not always been planned to meet people's individual needs and preferences and people's individual complaints had not always been recorded and investigated.

People told us the staff were kind, caring and treated them with dignity and respect however, some of the practices staff had used were not indicative of a wholly caring service.

Risks in relation to the spread of infection were managed well and people received enough food and drink to meet their individual needs. Checks on staff before they started working for the service to ensure they were of good character had improved, but needed further improvement to meet the required standards.

Consent was sought from people in line with the relevant legislation and people's wishes at the end of their life met. The staff enjoyed working for the service and felt the management were approachable and open.

We have made a recommendation to the provider to check that a digital platform they are using for communication meets the required regulations.

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 systems in place to ensure people received their medicines correctly was not effective.

Robust systems had not been in place to protect people from the risk of abuse or avoidable harm.

There were not enough care staff to cover the care visits that were required.

Checks on staff before they started working for the service had improved but still did not meet all requirements.

Learning from incidents and accidents had not been consistently applied.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Not all staff had received appropriate training which placed people at risk of receiving unsafe care.

People received support to eat and drink to meet their needs where this was appropriate.

Support for people's healthcare needs had not been consistently applied.

Consent had been obtained in line with the relevant legislation.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some staff practices had not been indicative of a caring service.

People had been involved in making choices about their care.

People's independence was encouraged.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care had not always been planned and delivered to meet people's individual needs and preferences.

People's complaints and concerns had not always been investigated.

People had been involved in the assessment of their care.

People's wishes at the end of their life had been respected.

Is the service well-led?

Inadequate

The service was not well-led.

The governance systems in place to monitor the quality and safety of care provided had not been effective leaving people at risk of receiving poor and unsafe care.

The provider had failed to ensure that actions they said they would take following the last inspection to improve the service had been implemented.

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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.

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.

On 6 November 2018 our expert by experience rang people to obtain their feedback about the service. On 19 November 2018, the inspectors visited the office to speak to the registered manager and view certain records. We gave the service 48 hours' notice of the inspection visit to the office because we needed to be sure that the registered manager would be available to talk with us.

Prior to this inspection we reviewed the information we held about the service. This included important events the service must tell us about by law, previous inspection reports and feedback we received from the commissioners of the service. We requested a Provider Information Return (PIR) from the provider but this was not received. The PIR is a document completed by the provider that tells us what they feel they do well and what improvements they plan to make to the service.

We spoke with four people and one relative who used the service, six staff which included care and office staff. We also spoke with the provider.

The records we viewed included five people's care records, four people's medicine records, two staff recruitment records, staff training records and other information in relation to how the provider monitored the quality of care people received.

Inadequate

Is the service safe?

Our findings

Following our last inspection of this area in November 2017, we rated safe as requires improvement. At this inspection have rated safe as inadequate.

At the last inspection we found that risks to some people's safety had not been managed well. We also found there had not been sufficient information in place to guide staff on when to give people medicines that had been prescribed on a PRN (as and when basis) and were concerned that people had not received their medicines as prescribed. This had resulted in a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found continued concerns in these areas and therefore the provider remains in breach of this regulation.

The systems in place to ensure that people received their medicines was not robust and did not comply with relevant guidance such as that from the National Institute of Health and Clinical Excellence (NICE). All the MARs we checked had gaps in them for both oral medicines and prescribed creams. This indicated that people may not have received their medicines as they should have done. The quality/training manager for the provider explained that people's MARs had not been audited for many months until they had completed this in October 2018. Some people's MARs had not been audited since April 2018. During the recent audit, they had found many errors with the completion of the MARs and had issued a general reminder to staff regarding this. However, they had not had time to check these errors to establish whether this had been a recording error or if the person had not received their medicine. The provider could not tell us if these people had received their medicines appropriately.

There continued to be no information available to staff in relation to PRN medicines. The staff we spoke with confirmed this. This is important so staff can judge if it is appropriate for a person to have these types of medicines.

For one person, the provider told us that staff were supporting them to take two oral medicines each day. However, there was no MAR in place to record this. The provider said they had tried to address this with the GP and pharmacy but to no avail. They told us the person had not had a MAR in place for approximately a year. A MAR is required where staff are administering medicines to a person so there is a clear record of what the person is being given. Not having one meant the provider could not monitor whether the person was receiving their medicines correctly.

Where staff were supporting people with the application of prescribed creams, the information available to staff was variable. Some records had body maps to show staff where they needed to apply creams but others did not. For one person their name or date of birth had not been written on the cream chart in line with NICE guidance and on another of their cream charts, there were no instructions regarding how often the creams needed to be applied. Not all staff who had been giving people medicines had been trained or assessed by the provider as being competent to do so safely.

During the inspection we became aware of an incident where staff had visited a person's home and found

that they had fallen out of bed. The provider had instructed the staff to lift the person off the floor with the blanket the person was sitting on. This is unsafe practice and put both the person and staff at risk of injury.

The local authority brought two incidents to our attention shortly after our inspection visit that had occurred in August 2018. The first had involved two staff who had manually lifted an individual instead of using the equipment provided. The provider confirmed this had been the case. They said the person had insisted the staff lift them as the equipment caused them pain and this was why staff had done this. However, this is poor practice and placed the person and staff at risk of harm or injury. On another occasion a staff member had moved a person on their own when they required two staff to do this safely. The provider told us that on this day, the second staff member had called in sick. They had arranged to attend the call with the staff member but when they got there, the staff member had already moved the person. This again was unsafe practice and demonstrated poor management of risk.

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

The quality/training manager told us there was now a more robust system in place to ensure that MARs were audited regularly and any issues investigated quicker. Staff had been reminded in recent team meetings to complete these records correctly. The quality/training manager said that staff were monitored more closely to ensure they were competent to give people their medicines. They also confirmed that the staff who had been giving medicines before being assessed as competent to do so, were no longer doing this. The provider told us they had communicated to all staff that moving people on their own or lifting was not acceptable and should not occur.

At the last inspection we found that adequate systems were not in place to protect people from the risk of abuse. This has resulted in a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider had not made the required improvements and therefore remained in breach of this regulation.

Four of the five people we spoke with told us they felt safe with the staff when they were in their home. One person told us, "I feel safe with the carers." However, one person said, "Not all the staff know how to use the equipment and they won't listen when I tell them I feel unsafe sometimes."

The local authority advised us of an incident in July 2018 where a person developed two pressure ulcers that the provider had failed to report to the relevant healthcare professionals for treatment. The provider advised they had asked a relative to do this but this was not done. However, the provider and staff had a duty of care to report this concern to a healthcare professional or the local authority. If they had done so, this may have prevented the person from experiencing harm.

During our inspection visit, the provider showed us the safeguarding incidents that had occurred at the service and that had been reported to us. At that time, we were not told about the three safeguarding incidents that were drawn to our attention by the local authority after our visit to the provider's office. This was despite the provider being aware of these. At our request they subsequently sent us their investigation into these safeguarding incidents but they had been written retrospectively on the 21 November 2018 which demonstrated poor record keeping. Also, we had not been informed of these three incidents at the time they happened by the provider. Three other incidents the provider had reported to the safeguarding authority had been reported to us retrospectively, some months after the event.

This was a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Records showed that since this incident, most staff had received further training in safeguarding and the staff we spoke with demonstrated a good understanding of the subject. Staff had also been given information regarding how to monitor people's skin more effectively and the staff we spoke with displayed a good knowledge within this area.

At the last inspection we found that robust checks of staff had not been completed before they started working for the service. This has resulted in a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that some improvements had been made and therefore, the provider was no longer in breach of this regulation. However, further improvements are required.

Checks of staff identity and whether they were barred from working within care or had any criminal record had been made. The provider had ensured that where appropriate, staff were legally able to work within the UK. For two staff members, a full employment history had not been recorded on their staff file and the provider could not tell us what their employment history had been. One staff member only had a character reference on their file and not a reference from their last employer. The provider had made attempts to obtain this reference but had not yet been successful. It had not been recorded within this staff member's file why they had left their previous employment but the provider was aware of this information. The quality/training manager advised that during interviews they asked staff about their health as is required.

All the people and the relative we spoke with told us that none of their care visits had been missed. Two people and the relative said staff always stayed for the allocated time and that they never felt rushed. However, two people said they did feel rushed by the staff. One person told us, "The carers come every day and I am rushed." Another person said, "I always feel rushed as the carers have too much to do in the time they have."

We received mixed views from staff regarding staffing levels. Three said they felt there were enough staff to cover care visits but three others said there were not. One staff member told us the service used to have six permanent drivers who would take staff to care visits but that this had reduced to four although six care rounds still needed to be covered. Another staff member said there were not enough drivers or care staff to cover holidays or sickness. Most staff told us they were not aware of any missed care visits although one staff member said one call had recently been missed due to a mix up of the rota.

All the staff told us they had enough time to spend with people to ensure they were safe and got the care they required. However, all three people's records we checked in relation to the time staff stayed with them during their care visit showed that some calls were being cut short. Of the 36 calls we checked over a random six-day period for one person, ten had been cut short by eight minutes or more, with some scheduled 30-minute calls being done in 10 minutes. For another person, nine of their 20 calls over five days had been cut short by 10 minutes or more.

The provider told us they could cover people's care visits but only with the use of office staff. This included the provider, the deputy manager and the assistant manager who were covering visits daily. The provider said this was necessary to ensure that all required care visits were covered and was because they had struggled to recruit more staff to the service. Minutes of staff meetings showed that these staff had been covering care visits since at least August 2018 and the office staff we spoke with confirmed this. This meant they could not fully complete the duties they had been employed to fulfil. There was a bank of staff recruited to the service but they could only cover care visits at certain times of the year. Therefore, there was

insufficient contingency of care staff available to cover care visits and when they were completed, they were often being cut short.

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

Incidents had not been consistently reported, investigated or learnt from. For example, records showed that in March 2018 a complaint had been made to the service regarding care that a person had received. A recommendation had been made by the local authority in relation to managing risks to people's skin. However, in August 2018 staff had not acted to reduce the risk of a person developing a serious pressure ulcer. In August 2018 there had been an incident where staff had used unsafe practices to move a person. This again occurred in September 2018 demonstrating a lack of learning. Other incidents or errors such as gaps in people's MAR had not been reported by staff as concerns so they could be investigated in a timely manner.

We were advised by some staff that the on-call system which was in place for people or staff to contact out of hour was not always effective. This was because the on-call phone was held by two staff who were often providing care visits and so were not contactable. Staff told us this had been raised as an issue with the provider on several occasions but not changed. An incident had recently occurred where a relative had called the on-call phone to report that staff had not arrived for a call but the phone had not been answered. This incident was known by staff but had not been reported or investigated so that lessons could be learnt and changes made to the on-call system.

Most people told us that staff used good practices to reduce the risk of the spread of infection. Staff told us they always wore gloves and aprons when providing people with care.

Requires Improvement

Is the service effective?

Our findings

Following our last inspection of this area in November 2017, we rated effective as requires improvement. At this inspection we have continued to rate effective as requires improvement.

At our last inspection we found that not all staff had received appropriate training and supervision to enable them to provide people with effective care. This had resulted in a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the required improvements had not been made and therefore, the provider remained in breach of this regulation.

Three people and one relative told us they felt staff were well trained. One person however, said they felt unsafe when staff helped them to move. We therefore checked the training staff had received and how the provider ensured they were competent to perform their role.

Since the last inspection, the provider had employed a quality/training manager who started working at the service in July 2018. They had reviewed the staff training programme and some had completed training in various subjects. However, several staff still required to attend training in some areas. For example, five of the 37 staff required training in health and safety and infection control, four in moving and handling, nine in first aid and 13 in food hygiene. Six needed training in medicines administration. The provider told us that seven people they were supporting were living with dementia but no training in this area had been provided.

During the inspection we found that some staff had been administering medicines when they had either not received training or had been signed off as competent to do so. Some staff had also used unsafe moving and handling practice that placed people at risk of harm.

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

The quality/training manager told us that plans were in place for staff to complete the training they required including subjects such as catheter care, pressure care and dementia. The provider told us that staff competency to provide care to people was assessed by the management team and the staff we spoke with confirmed this. The staff we spoke with told us the management team were regularly with them checking on their competency. However, records to confirm this had not been kept in all cases. The staff member responsible for checking staff competence periodically throughout the year told us they had not had time to do this formally and had so far completed 11 of these. The quality/training manager advised they had recognised that some staff were not receiving support to learn English where this was not their first language. They were in the process of arranging support in this area.

At the last inspection, we found that sufficient information was not in people's care records to guide staff on how to support them to make certain decisions about their care where this was needed. At this inspection we found that improvements had been made.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

All the people we spoke with told us that staff always asked for consent before performing a task. The staff told us they supported people who lacked capacity to make some decisions about their care. They demonstrated they had a good understanding of the principles of the MCA and said they always offered people choice. One staff member gave us an example of this by stating that they would show people different types of clothes to wear. Records showed that an assessment of people's capacity had taken place where it was felt they may require support to make decisions and there was some guidance in place for staff with regards to this.

People's care needs and choices had been holistically assessed. When they started using the service, people were visited by the provider who asked them what support they required. Areas such as their physical and mental health needs as well as cultural and spiritual preferences were explored. In some people's records, information about their life history had been captured to assist staff to strike up conversations with people. The quality/training manager told us people's life history was to be captured at the initial assessment if people wanted to disclose this information.

People who were assisted by the staff with their eating, drinking and healthcare told us they were supported in these areas to meet their needs. One person told us, "With regards to meals, I always get what I want."

The staff told us they felt they worked well as a team to deliver care to people. All care visits required two staff who worked frequently together. They were knowledgeable about the different healthcare professionals who could help people maintain their health. Examples were given of when staff had contacted a GP, the emergency services or an occupational therapist to review the equipment people had in their homes. For example, staff had been concerned when one person's pendant alarm started harming their skin. They had arranged for the GP to visit the person and review this. On another occasion, staff had contacted a district nurse due to being concerned about a person's risk of developing pressure ulcers however, we saw that this had not always occurred as was appropriate.

Requires Improvement

Is the service caring?

Our findings

Following our last inspection of this area in November 2017, we rated caring as requires improvement. At this inspection we have continued to rate caring as requires improvement.

At the last inspection we found that staff were not able to communicate effectively with people whilst delivering care. Also, people did not always see familiar staff which was a concern to them. At this inspection we found that some improvements had been made however, the service was still not always caring.

One person's care visits were regularly late which caused them distress and worry. Another person had developed a serious pressure ulcer whilst under the care of the service. Some staff had used unsafe practices to move some people which had placed them at risk of harm. These were not indicative of a caring service.

Four of the five people we spoke with told us that staff were kind, caring and compassionate. One person told us, "Everyone who comes is kind and caring." Another person said, "I have lovely carers I am very happy with all they do." One person had mixed feelings about staff telling us, "I have some good carers and some are useless."

People told us that the staff were respectful and polite and promoted their dignity. One person and a relative explained that nothing was too much trouble for the staff and that they maintained their or their family member's dignity always. Another person said they were always treated with the utmost respect.

People told us there had been some initial issues regarding communication with staff whose first language was not English. However, they said this had improved and that they were now able to communicate effectively with each other. One person and a relative described how they had built good friendships with some of the staff and looked forward to them visiting. People confirmed they usually saw the same staff which they preferred so they could build trust and help them to feel safe.

The staff we spoke with confirmed this feedback and demonstrated they understood how to protect people's dignity whilst providing them with care. They also knew the people they supported well and spoke about them in affectionate tones and understood their personalities and how they wanted to be cared for.

People told us they could express their views and were involved in making decisions about their care and that their independence was encouraged. Staff demonstrated they had an awareness of involving people in their care and promoting them to make decisions. They also described how they supported people to maintain their independence. For example, one staff member told us how they would encourage a person to do as much personal care as they could for themselves. The provider told us that promoting independence was a key objective of the service.

Requires Improvement

Is the service responsive?

Our findings

Following our last inspection of this area in November 2017, we rated responsive as requires improvement. At this inspection we have continued to rate responsive as requires improvement.

At our last inspection we received mixed feedback from people regarding whether they received personalised care and not all care records contained accurate information about people's needs. At this inspection we found that the required improvements had not been made.

Two of the people we spoke with and a relative told us they were happy that the care received met their or their family member's individual needs and preferences. One person told us, "I am really well looked after. When they first came the girls always asked me before they did anything for me and now I know them so well we just run side by side and everything gets done" Another person said, "I am confined to a chair and as a matter of course every time the carers visit they make sure I am comfortable and not at risk of pressure ulcers, they are all so kind."

Three people and one relative told us that staff arrived at the care visits on time and that they were informed if staff were running late, which they told us was rare. However, one person said staff were often late supporting them in the morning. The person explained this was important as they needed ongoing care for a medical condition for which they had to attend regular hospital appointments.

The person was very distressed about this when we spoke with them. On the day of our telephone call, the staff had not arrived by 10.10am. The person told us their transport was due to arrive at between 10.30am and 11am and that therefore, they were anxious that they would be rushed to get ready in time. The person said that on occasions they had missed their scheduled appointment. Although they had not come to any harm due to this as the hospital had seen them later in the day, they said they had had to wait up to four hours for the new appointment. This was not only an inconvenience to them but the transport and the hospital.

The provider told us this person's preferred call time was 9am. They said they were aware that the person required to attend critical appointments on certain days and therefore, had noted that carers should arrive around this time. However, records showed that only one of the eight calls in November 2018 that fell on these appointment days had been made at or around 9am. Six had been at 10am or after that time and one at 9.46am. This call had therefore not been planned or delivered in line with the person's preferences or needs.

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

Three people and a relative we spoke with told us they did not always know which staff would be attending their calls but said this was not an issue as they usually saw the same staff members. However, one person told us, "I never know who will be coming. I ask the carers and they either say it's them on the next visit or

not but they never tell me who will be coming if it is not them." This person explained it was important for them to understand who would be visiting. We therefore asked staff how they told people which staff would be visiting them and when.

One staff member said during the call staff would let the person know who was seeing them next however from the feedback we received, this system was not working. They told us that care visits were being scheduled for the following day, therefore people could not be given advanced notice of who would be visiting. They said plans were in place to schedule call visits two weeks in advance which would then enable them to advise people who would be visiting their homes.

We received mixed views from people regarding how easy it was to contact the office when they needed to. One person told us, "We never have trouble getting to speak to someone in the office and if the manager is busy he always rings back." However, another person said, "I can't get through to the office to speak to a human most of the time, frequently the answer machine is on, sometimes they get back to me but not always."

We also received mixed views from staff as to whether they could contact the provider or another member of the management team when they needed to. Some staff said this was not an issue but others did not agree with this. They said they sometimes found it difficult to speak with the provider as they were often out providing care. Therefore, they sometimes had to wait for advice and support.

People's needs and preferences had been assessed and people/relatives told us they had contributed to the process. Preferences such as what times people preferred their calls and the gender of carer they wanted to visit them had been discussed. One person told us, "Before the carers started coming we were visited by the manager and the care plan was done. He was very thorough; the carers always write in it when they come." People told us they were happy with gender of carer who provided them with care.

The care records we viewed contained some good information to guide staff on how to provide care to people to meet their individual needs. Some people had a laminated summary sheet detailing the care required. The quality/training manager advised this was a new initiative. They said this was being put in place following staff feedback regarding the amount of information that was within people's care records which took a long time for them to read. We found however, that some care records did not contain sufficient information within them to guide staff on how to safely provide people with stoma or diabetes care based on their individual need. The quality/training manager showed us some information they had recently given to staff regarding these areas to improve their knowledge but agreed to add the relevant information into people's care records.

People's communication needs had been assessed. The provider told us that where people needed documentation in a different format to aide their decision making, that this was provided. For example, in larger print or on different coloured paper. Other languages could be offered and a translator if needed.

At our last inspection we found that people's complaints or concerns had not always been acknowledged or responded to. We again received mixed views from people regarding this area.

People said they knew how to complain. One person said they had raised a complaint that had been dealt with quickly and to their satisfaction. They told us, "I had some problems at the start but we contacted the office and they took notice we have no problems now." One other person and a relative said they felt confident any concerns they raised would be listened to and rectified. However, two people said they had raised concerns that had not been acted upon.

One person told us, "I have tried to raise my concerns about my late calls but I am never taken any notice of." Another person told us how they had raised a complaint regarding staff practice in infection control. They said, "I have tried to complain to the manager but he says there are no other carers."

The complaints file we looked at did not have any record of these complaints being raised. Staff told us the management team were often visiting people and therefore concerns were raised directly with them. The deputy manager said these were dealt with as and when they occurred but were not recorded. Minutes of a team meeting held in September 2018 had recorded that people had raised complaints in several areas including staff being late, raising their voices to people and not doing what they should on care visits. However, only one complaint had been recorded as being received in 2018. There was no record of investigation or outcome to this complaint but the provider told us what action had been taken. Therefore, there were no records to demonstrate that people's individual concerns and complaints were being thoroughly investigated.

The provider was aware of people's wishes in relation to their end of life care. Records showed that the service had recently received compliments from relatives regarding this area. One compliment read, 'Such good care in the last few months of life. Thank you for the friendship and support.' Another said, 'Sincere thanks to all the carers who brilliantly attended to all [family members] needs. They looked after him with dignity and kindness.' The staff we spoke with told us they were also aware of this and assisted to help people have a comfortable death. Records showed that people had been consulted regarding some of their wishes, for example if they did not want to be resuscitated. The quality/training manager told us they were currently discussing this area with people who used the service and arranging for staff to have training within end of life care.

Inadequate

Is the service well-led?

Our findings

Following our last inspection of this area in November 2017, we rated well led as requires improvement. At this inspection we have rated well led as inadequate.

At the last inspection we found that the governance systems in place were not robust at monitoring or improving the quality and safety of care provided to people. This had resulted in a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the required improvements had not been made and the provider remained in breach of this regulation.

After our last inspection, the provider wrote to us and told us what action they would take to improve the service. They said that they would recruit more office staff to carry out various tasks and that they would spend more time in the office doing management tasks and ensuring audits were completed. However, the provider continued to spend most of their time visiting people and covering care visits. This meant they had failed to have adequate oversight of the service to ensure that regular audits and monitoring had taken place.

The medicines records (MAR) had not been audited for a long period, some going back as far as April 2018. The provider told us this was because the staff member responsible for this had been absent from the office for some months. However, they had not delegated this task to other staff to complete and this was why the MARs had not been audited. Therefore, potential medicine errors had not been identified or investigated in a timely way putting people at risk of receiving unsafe care. Furthermore, a recent audit conducted in October 2018 had found that some staff had been giving medicines to people without being signed off as competent to do so. These staff had given people their medicines in May, June, July and August 2018. Had the audits taken place when the provider said they should have done, this may have been prevented.

The provider had recognised that staff were not signing the MARs and there were many gaps and had reminded them about this in September 2018. However, they had not made provision at that time for these potential errors to be investigated or advised staff to report any they found as incidents. The quality/training manager told us that where medicines errors had occurred, there was no system in place to ascertain when staff may need re-training.

The provider had not ensured there were enough care staff working to cover the care visits. This had been raised as an issue within a team meeting in August 2018. Here it had been noted the deputy manager was having to cover the care visits in Cromer which was preventing them from performing supervisions of staff, planning care visits and organising training. This was still the case over three months later.

The provider told us that one way they monitored the quality of care people received was to randomly audit the task sheets that staff completed. These showed the times staff had visited people, how long they had stayed and what tasks they had completed. However, these audits had not taken place each month as the provider said they should have done due to a lack of staff in the office. Therefore, they had not identified that some people's care visits were being cut short by staff and that call visits that were critical to one

person's health and wellbeing, had consistently not been made when they should have been.

Minutes of staff team meetings showed that people had been raising concerns regarding late calls in September 2018. When asked, the provider was not able to tell us how many late calls there had been at the service in the last month. They had a tracking device that could be utilised to obtain this information. The provider said they checked this periodically and had been able to contact staff where they were running late. However, there was no system in place to regularly check this system and only the provider had access to it. It was acknowledged at the staff meeting in November 2018 that staff continued to run late and this demonstrated that a lack of improvement had occurred within this area.

Following the last inspection, the provider told us that by 30 June 2018 they would have in place a structured training and development programme for staff to ensure they had the necessary skills and knowledge to provide people with safe and effective care. However, although the completion of staff training was being monitored more closely since the employment of the quality/training manager in July 2018, staff had still not completed all the required training some 12 months after our last inspection. Also, during the inspection an incident came to light where the provider had instructed staff to use poor practice when lifting a person which demonstrated poor knowledge in relation to safe moving and handling.

The provider told us following the last inspection that all staff had rigorous supervision in place but these were behind as office staff had not had time to complete them.

There was no system in place to ensure that we had been advised of specific incidents that had occurred in a timely way as is required. Some had been sent to us retrospectively, several months after they had taken place. There was no system in place to analyse incidents or complaints for patterns.

Accurate and complete records in relation to people's care, complaints they had made or staff employment had not always been made. There were gaps in people's medicines records and in staff employment history. Although the provider said they were checking staff competency, records in relation to this were not always being kept.

This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had not been told about some incidents that we should have been notified about by law. These were in respect of risks that people had been exposed to in relation to their safety. We had been notified of three such concerns in November 2018 but the incidents related to July, September and October 2018 respectfully.

This was a breach of regulation 18 of the Care Quality Commission Registration Regulations 2009.

Prior to the inspection, we requested the provider complete a provider information return. This was issued to their designated email address. This was not received. The provider told us they could not recall receiving the request.

The provider used a digital platform to communicate the care visits to staff. These messages contained some data and confidential information about people using the service. However, the provider had not checked to ensure this usage meets the General Data Protection Regulations.

We recommend the provider checks with the Information Commissioner that this is this case as the data

may be stored outside of the UK which is not in line with the regulations.

The current systems in place within the office did not always enable the service to be well-led and to aide good communication. The staff and people using the service had an email address they could contact. However, only the provider had access to this. Office staff told us this meant they could not always check whether the service had been contacted by this method. Only the provider had access to the tracking system that enabled the tracking of care visits to take place. A new system had recently been put in place that now allowed office staff to log calls received from staff and people using the service. This helped them to track whether queries or concerns were being dealt with. This had been installed in October 2018 but one staff member told us they still did not have access to this system. To do this they had to use the provider's log in details and password which not good practice.

We received mixed feedback from people regarding the care they received. Two people and one relative we spoke with told us they were very happy with the care that was being provided. One person said they were happy with most aspects apart from the timings of some of their calls and the other person told us they felt the service was poorly managed.

The staff we spoke with were happy working for the service and told us the management team were open and approachable. They said they felt valued but some expressed frustration that they could not do the job they had been employed to do.

The provider told us they obtained feedback from people on a regular basis whilst out visiting them. They said that actions were taken immediately to correct any concerns. An annual survey was also issued to people. We viewed the last one conducted and saw that in the main, positive comments had been received. However, there were some negative comments and these had not been followed up. The provider said an analysis and action plan had been put in place following the return of the surveys but was unable to locate it.

The provider told us that links with the local community had been established for the benefit of people using the service. This included local NHS hubs to which people could be sign posted and social services.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had either failed to notify us or had not notified us in a timely manner of incidents of alleged abuse and a serious injury. Regulation 18 (1), (a) and (e).

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and treatment had not always been planned and delivered to meet people's individual needs and preferences. Regulation 9 (1), (3) (b).

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment had not always been provided in a safe way. Risks to people's health and safety had not always been adequately assessed and steps had not always been taken to mitigate risks as reasonably practicable. The provider had not ensured the proper and safe management of medicines. Regulation 12 (1), (2) (a), (b) and (g).

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

Systems and processes did not operate effectively to protect people from the risk of abuse or improper treatment. Regulation 13 (1), (2) and (3).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems and processes were not in place to assess, monitor and improve the quality and safety of the care provided or to mitigate risks relating to the health, safety and welfare of service users. Accurate, complete and contemporaneous records had not been kept in relation to each service users care and treatment or in relation to persons employed. The provider had failed to seek and act on feedback from relevant persons in the carrying out of the regulated activity to continually evaluate and improve the service. Regulation 17 (1), (2) (a), (b), (c) and (e).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent and skilled persons deployed to meet people's needs and ensure the appropriate running of the service. Some staff had not received appropriate support or training to enable them to carry out the duties they were employed to perform. Regulation 18 (1) and (2).