Community Angels Limited

Community Angels Ltd

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

This inspection took place on 8 and 9 April 2015 and was announced. This inspection was brought forward in response to concerning information received.

Community Angels is a community based service providing personal care and live-in care to people in their own homes. The service provides support and personal care to children, adults, older persons and people with physical and learning disabilities or continuing health care needs. At the time of our inspection the service were not providing support to children. There were 208 people using the service supported by a team of 98 care workers and nine office staff.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

Ensure that providers found to be providing inadequate care significantly improve

Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Summary of findings

Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

There was a registered manager in post who was responsible for the day to day running of the service. However the registered manager lived abroad and was not available to manage the service on a day to day basis. 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.'

People were at risk because the provider did not prepare staff effectively to recognise and prevent abuse and avoidable harm. Staff did not feel confident to raise concerns.

Recruitment and selection processes were not robust, appropriate checks had not been completed appropriately and in line with relevant guidance and the fitness of applicants had not been requested or explored, completed or checked. Gaps in employment and previous employment history had not been explored or completed on most application forms. Some applicants had met service users and shadowed staff members before the selection process had been correctly initiated.

Staffing levels did not always meet the needs of people. People's care had been cancelled on a number of occasions due to not having a member of staff to send to them. People were not happy with care workers whose first language was not English because the language barrier caused problems when communicating care needs. People were withdrawing from the service because there was not enough staff to meet their needs and provide the right care.

People, relatives and staff felt risks to people and staff were well managed and had no concerns. However we were not able to access all records relating to this.

Staff did not receive training that would effectively support people receiving care. Induction and training programmes were ineffective and did not equip staff with the confidence and knowledge they needed to support people safely. Supervisions were not completed in line with the provider's policy and did not effectively support staff.

The Mental Capacity Act 2005 was not understood and as a result could not be appropriately applied. Staff did not receive training on the Mental Capacity Act 2005.

People confirmed staff were caring however their privacy and dignity was not always respected.

People did not always receive care and support that was responsive to their needs. They told us of problems with late calls, rushed calls and cancelled calls. They found the office staff were not always responsive to complaints raised and requests were not always followed up. People's care plans were not always reviewed in line with the provider's policy which meant information about people could be out of date.

There was little evidence of leadership in the service and as a result the service was unorganised. Office staff did not know their responsibilities. Staff members that the registered manager advised would be responsible for the day to day running of the service were not always available or working at times to suit the running of the service. Notifications of important events and information about the running of the service were not always submitted to us.

There were few systems in place for auditing the service. These had not been followed up or acted on and recent questionnaires had not been collated or analysed and results had not been fed back to people.

Summary of findings

Information requested was not at hand which should be available at all times. For example, care plans were not always made available as paper copies had been archived and computer files were not always completed.

We identified multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found two breaches of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version 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. Staff did not receive sufficient training on safeguarding people from potential harm, could not identify signs of potential abuse and were not confident to raise concerns to management.

Recruitment and selection processes were not robust and relevant guidance for checking the character and fitness of staff was not followed.

There were not always enough staff to meet people's needs. The service was regularly cancelled because there were not enough staff available to send to people.

People felt risks were managed well.

Is the service effective?

Inadequate

The service was not effective. Staff did not receive sufficient induction, training and supervision to equip them with the skills and confidence to support people effectively.

Staff did not understand the Mental Capacity Act 2005 and how it applied to their role. Staff had not received this training.

People were supported to eat and drink in line with their care plan and were supported to access healthcare professionals when required.

Is the service caring?

Requires improvement

The service was caring when people received a service. People and their relatives told us staff were kind and caring.

Office staff spoke to people in a friendly and unrushed manner.

Staff were able to demonstrate how they respected people's privacy and dignity and most people felt their privacy and dignity was respected.

Is the service responsive?

Requires improvement

The service was not always responsive. There were problems with late calls, rushed calls and cancelled calls. The office staff were not always responsive to complaints raised and requests were not always followed up.

People's care plans were personalised and staff followed the care plans in people's homes, however people's needs were not always updated and reviewed in line with the providers policy or as and when people's needs changed.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led. There was little evidence of leadership in the service and as a result the service was unorganised. Office staff did not know their responsibilities. Statutory notifications were not always submitted.

There were few systems in place for auditing but these had not been followed up or acted on and recent questionnaires had not been collated or analysed and results had not been fed back to people.

Information and records requested which should be available at all times was not at hand during the inspection.

Community Angels Ltd

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.'

This inspection took place on 8 and 9 April 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection team consisted of one inspector and two experts-by-experience who made phone calls to people who use the service to gather their views on the care provided by Community Angels Ltd. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. One expert's area of expertise was elderly care, stroke and rehabilitation, and they had a background in occupational therapy. The other expert had personal experiences of receiving care services.

Prior to the inspection we reviewed information we received about the service and looked at notifications received from the provider. A notification is information about important events which the provider is required to tell us about by law. We spoke with two social care professionals to obtain their views on the service and the quality of care people received. We asked the provider to complete and send a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. However this was not submitted at the time of the inspection.

On the day of the inspection we spoke with 22 people who used the service, 15 relatives and two visiting social workers. We interviewed eight care workers, the deputy manager, Finance assistant and two office staff. The registered manager was not available as they were living in another country.

We reviewed a range of records about people's care and how the service was managed that included the care plans for 10 people, risk assessments, medicine records, daily reports of care, incident logs, minutes of meetings, and specific records relating to people's health and choices. We looked at recruitment and supervision and training records for eight staff members and service quality audits.

Inadequate

Is the service safe?

Our findings

The majority of people and relatives we spoke with said they or their relatives felt safe when receiving care. Comments were mostly positive with people stating "yes, I do feel safe, definitely," and "very safe, no problems." However some comments received were not so positive. For example, one person told us they felt safe with some care workers but not with others. A relative said, "It's all safe, yes, (my) relative feels okay with the majority of them." However all felt they could raise concerns with the office, or with the care workers themselves.

People were not always protected against the risk of avoidable harm and abuse because effective measures were not put into place to ensure their safety. The finance assistant and deputy manager told us care workers induction included training on safeguarding adults, and recognising signs of abuse. However eight care workers told us they had not received safeguarding training as part of their induction programme. Five out of eight said they had never attended a safeguarding course. Training records showed only two out of 98 care workers had completed this training.

When we spoke with care workers, six understood how they could keep people safe from harm, this included recognising unexplained bruising and marks or a change in behaviour. However two did not understand what safeguarding meant and could not identify types of potential abuse or recognise the signs. Five out of eight care workers said they would not report any concerns to their manager because they did not have confidence in management to deal with safeguarding concerns. However three care workers told us they would report concerns but questioned whether the concerns would be dealt with if they did. This meant the provider's training and policies for safeguarding people from potential harm were not effective in preparing care workers to identify signs of potential abuse and to respond appropriately. This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

We had been notified of eight safeguarding incidents or concerns in the past eight months. These included substantiated allegations of missed calls, insufficient support to inexperienced care workers and recruitment checks not being completed sufficiently. However there were no records available in the safeguarding folder to show how the previous registered manager, who had left the service in January 2015, had investigated concerns.

We had not always been notified of safeguarding concerns. We found a complaint that had been received by the service on 21 January 2015 which had been identified as a safeguarding concern. Meetings had taken place with the local authority safeguarding team and this was still on-going. However we were not notified of this. We spoke with the deputy manager who advised they did not know that we needed to be notified. This was a breach of Regulation 18 of the Health and Social Care Act (Registration) Regulations 2009.

Staff and people we spoke with said there was not always enough staff to meet people's needs. Six care workers told us that the people's care had been cancelled on a number of occasions due to not having a member of staff to send to them. This was confirmed by eight people we spoke with. One person said many of their visits were cancelled or missed because care workers did not turn up or they would receive a call from the office to inform them the call could not be covered because they did not have anyone to send. Another person told us they were not happy with the care workers they had as the care workers first language was not English and the language barrier caused problems when communicating care needs. Two people told us they were withdrawing from the service because there was never enough care workers to meet their needs and provide the right care. Care workers confirmed a number of people had cancelled the service because they did not always receive support.

We spoke with one care worker, whose first language was not English and they found it difficult to understand and comprehend the questions they were being asked. They confirmed they had trouble understanding the English language and could not always understand what people were asking when providing support. This care worker had been providing support to a person with complex health needs which included support with administering medicines via a Percutaneous Endoscopic Gastrostomy feeding tube (PEG). We spoke to the deputy manager and asked what processes were in place to assess overseas applicants comprehension of the English language prior to completing the recruitment process and they told us they did not check. On the second day of our inspection the

finance assistant told us this care worker had been removed from providing support to this person and their employment had been terminated with immediate effect. Although the concern had been dealt with and the immediate risk to this person removed, this meant staffing may not always be suitable to keep people safe and meet their needs.

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

Safe recruitment and selection processes were not followed in line with the provider's recruitment policy. Gaps in employment and previous employment history had not been explored or completed on seven out of eight application forms. There was no evidence that interviews had taken place for all eight applicants. Two office staff told us applicants had met people and shadowed care workers before the selection process had been initiated and appropriate checks had been carried out. Two care workers confirmed they had not completed their recruitment process and had been providing support to a person with complex health needs.

Recruitment and selection processes were not robust to ensure the safety of people. Appropriate checks had not been carried out to ensure staff were suitable to work with in a care setting. For example; out of eight staff recruitment records viewed, six did not contain references. The provider's policy stated "A minimum of one reference is required." Schedule 3 of the Health and Social Care Act 2008 requests that satisfactory evidence of conduct in previous employment with the provision of services relating to health and social care is gathered. This meant the provider did not follow their recruitment policy or meet the requirements of schedule 3 of the Health and Social Care Act 2008.

Disclosure and Barring Service (DBS) checks were not always submitted or completed for applicants before they started working. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. For example; five out of eight staff recruitment records showed that a DBS had not been submitted or received prior to them starting work. For two staff the equivalent process for overseas applicants had not been followed." One member of staff's DBS highlighted a number of offences. A discussion had not taken place on the subject of any offences or matters that might be relevant to the position. A risk assessment had not been completed to determine the level of risk to people. Another member of staff told us they had made the registered manager aware of the number of offences they had committed during their interview however a discussion had not taken place, and a risk assessment had not been completed prior to offering work. The provider did not have a written policy on the recruitment of ex-offenders. The Code of Practice published under section 122 of the Police Act 1997 obliges registered bodies to have a policy of the recruitment of ex-offenders. This meant the provider did not have robust processes in place to ensure that applicants were of good character.

One staff member who was responsible for the recruitment of care workers said applicants were taken to meet people in their homes prior to the interview and checking processes. The staff member confirmed the applicant would shadow an experienced care worker providing personal care to people and this would help the applicant and the provider decide if they wanted to progress with the recruitment process. The staff member could not guarantee that applicants were not left alone with people. This meant people were put at risk of potential harm as the relevant recruitment and selection checks had not been completed to ensure the applicant was of good character prior to the applicant meeting people.

The fitness of applicants had not been requested, explored or reviewed. The provider did not have the correct processes in place for considering an applicant's physical and mental health in line with the requirements of their role. Application forms did not request this information and when we spoke with the deputy manager they told us they did not realise this information had to be requested. One member of staff told us they had a health condition which could result in them taking time of work. This had been discussed with the registered manager prior to their interview however this had not been documented and there was no evidence to show that the provider regularly reviewed the fitness of the member of staff. This meant the provider did not have appropriate arrangements in place to deal with staff who were no longer fit to carry out the duties required of them.

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

Of the 23 people and 15 relatives we spoke with 13 people received support with medicines and said it went very well.

Inadequate

Is the service safe?

One person said they had a catheter and the care worker "does the night bag really well". One relative said, "They help [relative] take the tablets from the Nomad, they also give [relative] paracetamol if [relative] needs it, and let us know when [relative] needs more." A Nomad is a medicines storage device designed to simplify the administration of oral dose medicines.

Staff members we spoke with all knew what support people required with their medicines and felt the information given about people's medicines were detailed enough to support them safely Medicines management plans were in place for those people who required support with their medicines. This identified the level of support the person required with their medicines and if they were able to self medicate. Of the ten care records viewed we found four people had these present in their care plans. We were unable to evidence this for the other six people as the information was not accessible due to the service transferring over to a paperless system. This meant we could not be assured that information was up to date or accurate as a proper system and process was not fully in place. This was a breach of Regulation 17 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

The provider did not ensure that staff providing care to people had the qualifications, competence, skills and experience to do so safely The finance assistant told us all care workers received medicines training as part of their induction programme. However six care workers told us they had not received medicines training before working with people. One care worker informed us they had been administering a person's medicines via a Percutaneous Endoscopic Gastrostomy feeding tube (PEG) without any prior training on medicines or PEG. Another care worker told us they had not received any medicines training and was not confident supporting a person who required medicines to be administered via a PEG. The care worker told us they had to keep asking the relative to check if they were doing it right. Records showed most staff had completed medicines training however this was only evident by a tick and a date was not present to identify how long ago the training was completed. This meant people were at risk of not receiving appropriate support with medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives were satisfied risks were identified and assessed to make sure care and support were delivered safely. One relative said, "There are no risks, they are fine." Another relative said "They manage risks by thinking ahead." The deputy manager and finance assistant told us risks were assessed and managed as part of people's initial needs assessments and would be updated annually or when a person's needs changed. These included risks to people's safety and risks to staff associated with providing care and support in people's homes. In the care plan records we looked at we saw risks were documented for some people, for instance risks associated with moving and handling and environment. The risk assessments included action plans to reduce and manage the risks. However we were unable to see if these were completed for all ten people as the information was not made available. We were told this was as a result of the provider transferring over to a paperless system and all computerised care plans had not be completed. Paper care plans had been archived and the office staff did not know where they were kept. This was a breach of Regulation 17 of the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People told us their care workers were mostly skilled and experienced. We received comments such as, "Very experienced", "Oh, yes, they know their job", and "Very skilled." However some comments received were not positive. For example, one relative commented, "The older ones are okay, the younger ones are still learning." One person said, "I think they could improve the training. They don't have enough." Another person said, "The occasional one has not been trained enough."

The staff induction programme was ineffective and did not equip care workers with the confidence and knowledge they needed to support people safely. Most care workers told us they did not always feel confident to support people following their induction training and often relied on the relative of the person or the person themselves to tell them what to do. One person told us care workers were not trained to be able to care for their complex needs and use their equipment. They said, "They do not know what they are supposed to be doing and have no clear role." The deputy manager told us staff were expected to complete the basic induction module, medicines and manual handling through on line computer-based learning before they were able to shadow experienced workers or work on their own. All care workers expressed concern that the on line theory based manual handling course was not sufficient to help them provide safe manual handling practice for people. One said, "E-learning with manual handling and watching two experienced carers using a hoist is not effective training. There's a lot of trial and error and it is uncomfortable for both staff and client."

We spoke with a care worker who told us they had been providing support to a person with complex health needs by administering medicines via their Percutaneous Endoscopic Gastrostomy feeding tube (PEG). The care worker had attended training for supporting people with a PEG on the day of the inspection but had not attended any training prior to supporting this person. The care worker confirmed they needed to check with the relative of the person that they were completing the task correctly. We found the care worker had not completed their induction training and the deputy manager told us they should have only been shadowing an experienced care worker and not completing care tasks. This meant that staff had been sent to provide care to people who were not adequately trained and as a result could provide ineffective support to people.

Staff training was inconsistent and records showed that many staff had not attended all of the required training courses. Most training was provided by an external provider through e-learning courses. Care workers and office staff felt the training was not effective and were not satisfied the training prepared them adequately to support and care for people. One member of staff said, "e-learning is not great, I would like to ask questions and it does not give you the opportunity." Another said, "We rely on the relative or the person to train us. I have been asking the client's relative to check that I am doing things right." This meant staff were not always supported to provide effective care through a programme of induction and regular training.

Supervisions were not completed regularly or in line with the provider's policy and did not effectively support staff. It was identified in the office team meeting minutes on 17 March 2015 that "Staff supervisions and spot checks need to be caught up on." A spot check is a observation test made without warning on a selected subject. We saw a number of spot checks had been completed in March 2015 following the office team meeting, however supervisions had not been completed and actions identified from the spot checks had not always been followed up or acted upon. For example on one care workers spot check we saw medicines training had been highlighted for the person to complete. However we could not see any evidence this had been actioned and the member of staff responsible for recruitment and training was not able to provide evidence of this.

Staff meetings did not take place regularly. A team meeting was being carried out on the day of the inspection to discuss a person's support and arrange cover for their care calls. However three staff members who had attended this meeting told us this meeting had not happened before. We saw minutes of an office staff meeting that took place on 17 March 2015. The minutes identified the next scheduled meeting would be 24 March 2015. However two members of office staff confirmed that the meeting on 17 March 2015 was the only meeting that had taken place and the meeting on the 24 March 2015 did not take place. This meant staff did not have effective support, training, induction and

Inadequate

Is the service effective?

supervision to enable them to care for people effectively when starting work and on an on-going basis. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) and its associated code of practice was not understood and as a result could not be appropriately applied. The MCA and code or practice provide a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. When asked what staff understood by the MCA and how they would apply it in their role, staff did not know. One member of staff said, "I do not know, is it where your job is your job, keep professional?." Another said, "I do not know what it means, is it something to do with dementia?." Staff and training records confirmed that training on MCA had not been provided to staff. There was no manager available for us to speak to in order to check this.

Where people were able to consent to their care and support this was not recorded by means of a signature on their care plan. If they were not able to sign but had indicated their consent by some other means, this was also not recorded. Care records had not been signed by people to indicate that they consented to care being given. Paper copies were not available as the service was moving to a paperless system, therefore this was difficult to evidence. Failure to apply the principles of the MCA was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were supported to eat and drink enough when required and some people confirmed care workers prepared their food well. The office staff told us some people had lunchtime calls because they needed assistance to eat. They said all care workers knew how to do this, and there was specific guidance in their care plans, for instance if they needed their food to be cut up. Care workers told us they made sure people had drinks available when they left. They told us they received instruction from the office to pay particular attention to fluids during hot weather. However not all staff had received training in basic food hygiene.

The registered provider told us care workers or office staff would make arrangements to contact people's doctors or paramedics if necessary. Staff had arranged for an occupational therapist to attend when concerns were raised about another person's mobility and people were supported to attend hospital appointments.

Requires improvement

Is the service caring?

Our findings

People and their relatives found their care workers to be caring. One person said, 'definitely all caring." One person referred to their care workers as "little angels." Another person said, "I would trust them all, implicitly." All felt carer workers spoke respectfully to them and were polite. The majority or people and relatives said the office staff were also polite and respectful. One person said, 'the office are without a doubt, polite." One person added, "I know all their names at the office, they are lovely to me, saying, that's no problem."

However, our own observations and the records we looked at did not always match the positive descriptions people and relatives had given us. The service was not consistently caring as people did not always receive care when they needed it because the service did not always have enough staff to send to them.

We saw compliment cards had been received from people and relatives thanking the care workers and office staff for their support and kindness. For example, one said, "Just a note to thank you for the wonderful care my [relative] had from angels." Another said, " Thank you for the love and care you have showed [relative] on your visits to them, thank you." Staff confirmed these compliments were passed onto the care workers.

Observation of discussions which took place between care workers, office staff, people and people's relatives on the day of the inspection were positive. Given the small number of office staff working in the office, telephone calls were responded to quickly and in a caring and thoughtful way. Telephone calls did not appear rushed and concerns were dealt with in a timely manner.

People felt their views were listened to and had good experiences of how much they were able to express their views and be involved in decisions about their care and support. One person told us they had contacted the office to inform them that they did not want a care worker to leave them alone when completing personal care. They confirmed the office had listened and the support was changed straight away. Another person said they had told one of the care workers that they did not feel comfortable with a particular care worker and it was dealt with straight away.

Most people confirmed staff respected their privacy and dignity at all times. We received positive comments such as, "They [care workers] will even shut me out of the bathroom while they are looking after [relative].", and "Very respectful." However one person and a relative did not feel privacy and dignity was always respected. One relative said, "They are much better about [relative] privacy now." One person told us they had been contacted by the office on a Sunday to inform them there was no care worker available to attend to their personal hygiene that evening. The office asked them if their [relative] could provide their personal care, however the person stated they did not want their [relative] to provide their care. Care workers gave us practical examples of how they promoted people's dignity and privacy, such as, closing doors, pulling curtains and covering up people when completing personal care.

Requires improvement

Is the service responsive?

Our findings

People did not always receive care and support that was responsive to their needs. They told us of problems with late calls, rushed calls and cancelled calls. They found the office staff were not always responsive to complaints raised and requests were not always followed up.

When care was provided most people and their relatives confirmed their care was delivered by a main care worker or from a small team of regular carer workers. We received comments such as, "It's normally the same one", "For four days, it's the same one, at least", "There are 2 or 3 regular ones." However some comments were not so positive and included, "They can be all different carers", "Not sure how many different ones." Most people and their relatives told us their care workers were always late but did stay for the full duration of the visit. One person said, "Not good time keepers." Another said, "[Care worker] was late this morning, over an hour. The bath gets cold. It (the service) fluctuates every week." Staff members confirmed that on regular occasions people are contacted to inform them that they do not have a care worker to send to them and would ask a relative to help. Sometimes this meant people would go without personal care support. We saw evidence from daily records that people had not received care calls. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People confirmed they had a care plan in their home and that care workers followed the plan of care. However most people could not answer whether they had been involved in their care planning, but they accepted the plan had been built around their needs. One said, "I just wanted them for a bath." Another person felt they were making their own decisions and confirmed the care workers would do anything they wanted. Care plans were not always easily accessible as the office was moving to a paperless service. Out of the ten care plans viewed only four contained information concerning the person's needs because the other six were not available. However all four care plans were very detailed in their completion, and they contained information about people's medical history, mobility and personal preferences of how they would like their personal care completed. For example one care plan requested care workers assisted the person with their personal care according to their preferences for drying, creaming and dressing. This care plan detailed precisely how the person would like to be supported and included tasks which the person was able to do for themselves.

People's care plans were not always up to date and reviewed in line with the provider's policy on reviewing people's needs. The provider's policy states that people's care plans will be reviewed annually or as and when a change of needs arise. Of the four care plans we viewed only one care plan had been updated in line with the provider's policy. People and relatives were mixed in their response to care plans being updated. One relative said they were annoyed that their relative's last review was two years ago and their condition has changed since then. They said, "[relative] has gone downhill but the person who did the reviews left 18 months ago, it is too long". Staff members confirmed reviews had not been completed for some time because the person responsible for this role had left. A new staff member had taken on the role of reviewing people's care plans and was working towards updating them. However they told us they did not always have time to complete reviews as they were working on other tasks they had been given. This meant people were at risk of not receiving appropriate, safe care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Most people had not made a complaint. We received mixed feedback from people who had raised a complaint with the office. Some people found the office responsive when they contacted the service for information or to raise a concern or complaint. For example, one person told us they had contacted the office due to a care worker's lack of skill and knowledge regarding their care needs and the office had stopped the care worker visiting them to complete personal care tasks. However three people told us they had made complaints about care workers running late and this was still happening. One person said, "A couple of times a month they ring to say they are running very late and then we have to make other arrangements. This is still happening and not very satisfactory."

There was a complaints file which contained one record of a complaint which had been followed up as a safeguarding concern and a complaints breakdown form. Missed visits had been identified as a regular cause for complaints,

Requires improvement

Is the service responsive?

however no learning had taken place and this was still a cause for concern at the time of our inspection. This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

When we spoke to people about the management of the service we received varying responses. Most people gave us positive comments and thought the service was well managed. One said, "I think well run, on the whole." Another said, "The office are all good. I know all their names. They would do anything for me." Some people and their relatives told us they felt the service was mainly well managed. However some people were happy with the care workers but not with the office staff. One person said, "When I cancelled [the service], they stopped it, but still charged me. They never said why." Another commented, "Messages do not get passed on, they don't ring you back. The carers are brilliant; the only problem is the office." Three people did not feel it was well managed.

We heard varying opinions of the culture of the service. Some people said the service was well run and they would recommend it. However some people told us the office was "good at passing the buck" and that the care workers do not know what they are doing from one day to the next. Care workers were also divided in their opinion of how the service was managed. Some were not clear who was in charge in the office. Staff we spoke with told us they did not know who was in charge. One said, "Half the time I do not know who I am speaking to, I do not know who is the manager." Some found the senior staff to be supportive and described it as a good place to work. Others were frustrated by poor communication, the lack of response when concerns were raised and what they saw as poor organisation in the office. They felt the service did not respond well to unexpected circumstances, such as care workers going sick and people having their calls cancelled.

There was little evidence of leadership in the service and as a result the service was unorganised. Office staff did not know their responsibilities. It was evident from our observations that office staff appointed to manage the service were not always available. This was as a result of their contracted hours, long term unplanned leave or planned leave. Not all office staff were aware of their responsibilities, did not understand their role fully and did not have an appropriate contract in place which outlined their roles and responsibilities. One said, "When I joined the service I thought it was for a permanent position but I have just found out it is temporary. I also do not have a contract or a job description and I am not sure what I am responsible for doing."

There was a registered manager in post but they were not present on a day to day basis to oversee the running of the service and at the time of our inspection were living abroad. The previous registered manager left in January 2015. The registered manager appointed a deputy manager to oversee the running of the service on a day to day basis, however they were not always available. This was a breach of the provider's condition of registration and Regulation 5 of the Care Quality Commission (Registration) Regulations 2009.

Prior to the inspection we asked the provider to complete and send a Provider Information Return (PIR). However this was not submitted at the time of the inspection. Our records showed an email had been sent to the provider on 13 November 2014 requesting completion and submission of the PIR by 16 January 2015. We sent an email to the provider on 1 April 2015 reminding them of their responsibilities regarding the completion and submission of the report which was required under Regulation 17(3). The provider did not respond to the email sent. This meant the provider was in breach of Regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had not received any safeguarding notifications from the provider since the previous registered manager left in January 2015. A notification is information about important events which the service is required to tell us about by law. We saw a complaint had been received and was being dealt with as a safeguarding concern. However the deputy manager was not aware that we should have been notified of this concern. This meant the service did not always follow the legal obligation to send notifications to us and as a result we were not always aware if safeguarding referrals were being effectively monitored. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There were few systems in place for auditing service delivery, such as a monthly complaint breakdown form, which included the total number of safeguarding concerns and accidents and incidents raised. The most recent complaint breakdown form was completed in March 2015 and contained very little information. Actions had been

Inadequate

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identified to monitor the safeguarding concern raised. All other sections had not been completed. There was no evidence to show that accidents and incidents had been reported, audited or learnt from.

Client feedback questionnaires had not been collated or analysed. The provider undertook a quality assurance survey in October 2014 and 44 questionnaires had been returned. This showed that 50% were not happy with the reliability of the service. 23 out of 44 people felt their care was rushed and 39 people stated care workers did not arrive on time. People confirmed they had completed questionnaires but had not been provided with any feedback. The feedback we received from people showed these were still problems more than six months later.

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

The service was moving to a paperless service which meant all care plans and paperwork to do with the service such as information about people and staff would be kept on a computer database. Information requested was not always made available. For example, care plans were not always made available as paper copies had been archived and computer files were not always completed. Staff members did not know where paper copies had been archived. This was a breach of Regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the service offered a reward scheme to care workers who had gone the 'extra mile'. Care workers would be issued with either a bronze, silver or gold angel badge and given a bonus in their pay each month, for either supporting the office with completing reviews, spot checks or taking additional work. One staff member told us they received a gold angel badge for completing risk assessments for people. They said, "It is a really good incentive. People know what the badges mean and they would say we have a special angel today."