Handle With Care (Portsmouth) Limited

Handle With Care

Inspection report

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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

We carried out this unannounced inspection on 13 July 2017.

Handle With Care provides personal care services to people living in their own home. At the time of our inspection there were 167 people receiving this service. There were 56 staff members who provided personal care to people which included two senior managers, one trainee manager, three senior care assistants, five risk assessors, and two co-ordinators.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The overall rating for this service is 'Inadequate' and the service is therefore 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 take action 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.

At our last inspection in November 2016 we found safe medicine practices were not followed. At this inspection we found safe medicines practice continued to not be followed.

At our last inspection in November 2016 we found risk assessments were completed but not always dated and did not contain all the information on how risks to people could be minimised. At this inspection we did

not find an improvement with this concern.

At our last inspection in November 2016 we found safe recruitment processes were not followed. At this inspection we found safe recruitment practices continued to not be followed.

At our last inspection in November 2016 we found staff training was not always effective. Staff competencies were not checked and staff did not receive an effective supervision to support them to carry out their duties. At this inspection we found training and supervisions did not always equip staff with the skills and knowledge to support people effectively because their competencies were not checked.

At our last inspection in November 2016 we found consent was not always sought when people were considered to lack capacity. At this inspection we found staff and the registered manager demonstrated an improved knowledge of how to support people who lacked capacity to consent to their care.

At our last inspection in November 2016 we found assessments of need were not always completed prior to the commencement of care. Care plans contained insufficient detail regarding people's preferences, choice, wishes and risks and the information in care plans were not always accurate. At this inspection we found care plans contained people's preferences, choice and wishes.

At the last inspection in November 2016 we found systems to assess the overall quality and safety of the service were not in place. At this inspection we found quality and safety audits were in place but they were ineffective and records were not complete in respect of each service user and staff member.

At our previous inspection in November 2016 we found the Commission were not always notified of safeguarding concerns. At this inspection we found the Commission had been notified, however, there was a delay in notifying the Commission of these safeguarding concerns.

The rating from the previous inspection in November 2017 had been clearly displayed in the front office of the service, however; the rating had not been displayed on the website.

Staff felt mostly supported but did not have a lot to do with the registered manager. Team meetings did not take place. People felt the management were unorganised and lacked effective communication.

Although people experienced missed visits, late and rushed calls, particularly during times of unplanned staff absences, there were enough staff.

Safeguarding concerns were not dealt with appropriately.

People's dignity and privacy was not always respected and staff were not always kind, caring or compassionate. Communication was not always effective between care staff, people and the office.

An effective complaints process was not operated.

People were supported to eat and drink effectively and access external health care professionals.

People were involved in their assessment of needs, development of their care plan and were involved in making daily decisions about their care requirements.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014 and one breach of the Care Quality Commission (Registration) regulations 2009. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Medicines were not managed or disposed of safely.

Risks to people were unclear and not managed safely.

Safe recruitment practices were not followed.

Safeguarding protocols were not followed.

There were enough staff.

Is the service effective?

Requires Improvement

The service was not always effective.

Training and supervision were not always effective with equipping staff with the skills and knowledge to support people.

The principles of the Mental Capacity Act 2005 were understood.

People were supported to eat and drink and have access to external health care professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were not always kind, caring and compassionate and did not always respect people's dignity and privacy.

People involved in decisions about their care and were encouraged to remain independent.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Complaints were not effectively managed.

People's needs were not always responded to effectively.

People were involved in the assessments of their needs, the development of their care plan.

Care plans were personalised with people's choices, preferences and wishes.

Is the service well-led?

Inadequate

The service was not well led.

Ineffective control measures were in place to manage the overall quality and safety of the service and records were not always complete.

Management was unorganised and did not communicate effectively.

Staff did not receive team meetings and did not speak with the registered manager often.

There was a delay in sending notifications to the Commission.

The previous inspection rating had not been displayed on the website.

Handle With Care

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 13 July 2017 and was unannounced. This inspection was brought forward due to concerns of a safeguarding nature and to follow up on the warning notices served on the provider to confirm they were meeting their legal requirements after our inspection in November 2016.

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

Before the inspection we reviewed previous inspection reports, safeguarding records and other information received about the service. We checked if notifications had been sent to us by the service. A notification is information about important events which the provider is required to tell us about by law. We spoke with the local authority safeguarding team.

During the inspection we spoke with 18 people who were receiving personal care from this service, 11 relatives, seven care workers, two senior managers and the registered manager.

We reviewed a range of records about people's care and how the service was managed. We looked at plans of care for seven people which included specific records relating to people's preferences, capacity, health, choices, medicines and risk assessments. We looked at daily reports of care, incident and safeguarding logs, compliments, complaints, service quality feedback forms, audits and minutes of meetings. We looked at the training plan for 56 staff members and recruitment records for two staff members and supervision, appraisal and training records for four staff members.

We asked for some information to be sent to us after the visit. This information was received.

Inadequate

Is the service safe?

Our findings

At our previous inspection in November 2016 we found people's medicines were not being managed or disposed of in a safe way. We found this to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served a warning notice and told the provider they were required to become compliant with this regulation by 1 February 2017.

At this inspection we found this regulation had not been met because sufficient improvements to meet the warning notice and the regulation had not been made. Further concerns had been identified with the unsafe disposal and management of people's medicines. We raised a safeguarding alert to the local authority as a result of the concerns we found and wrote to the registered manager to ask them to take immediate action to reduce the risk to people.

Staff confirmed they were disposing of medicines in an unsafe manner. The National Institute for Health and Care Excellence (NICE) guidance, Managing medicines for adults receiving social care in the community, March 2017, stated that 'When social care providers are responsible for disposing of any unwanted, damaged, out-of-date or part-used medicines, they must have robust processes, in line with The Controlled Waste (England and Wales) Regulations 2012, which included returning medicines to the pharmacist to be disposed of. One staff member said they continued to dispose of people's medicines down the sink or toilet. Another staff member told us they disposed of one person's transdermal patch by placing this in the person's dustbin. A transdermal patch is a medicated adhesive patch that is placed on the skin to deliver a specific dose of medicines through the skin and into the bloodstream. When a transdermal patch is removed from a person's skin there is still some active drug within the patch. Therefore the correct disposal of these medicines should be to fold the patch on itself so that the active surface is no longer visible and return to the community pharmacy. Other staff members said they disposed of people's medicines by placing them in money bags, a piece of tissue or a sandwich bag and kept them in their handbags or vehicle glove compartments until they could take them into the office or pharmacy.

The disposal of people's medicines were not being monitored safely. The registered manager, senior manager and staff told us they removed medicines from people's tamper-proof nomad and disposed of them each time the person refused their medicines. A nomad is a type of monitored dosage system with a specially designed seal to ensure the system is tamper-proof and contains people's medicines. Although the registered manager had implemented a Medication Disposal Form there was no system in place to ensure the correct amount, dose and type of medicines were being removed. This meant there was a risk that the number of medicines being removed had the potential to go missing, or be misused in other ways.

Reasons for the refusal of medicines were not explored in line with the provider's policy to ensure people were supported to take their medicines. Records did not demonstrate the necessary action which had been taken to ensure people received the medicines they were prescribed. The providers supervising medication policy revised in July 2017 stated, "If clients refuse (medicines) a decision can be made about trying an alternative method." Documents evidenced people had refused antipsychotic, anti-depressants and other medicines which had been prescribed for their health. We raised these concerns with the registered

manager and asked them to take immediate action to ensure people's medicines were safely managed and disposed of.

People shared their concerns about the lateness in visits and the impact that this had on them receiving their medicines. One person said, "I take my own medicines but if they are late which happens a lot it means I'm taking my medicines late, I have to have them with food which they prepare for me." One relative told us care staff did not stay and ensure their relative took their medicines because they were late and rushed.

A failure to safely manage and dispose of people's medicines was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection in November 2016 we found risks to people were not appropriately identified, assessed or action taken to minimise the risk to people and others. We found this to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to send us an action plan telling us how they would meet this regulation. Following that inspection the provider sent us information which said they had taken immediate action to address our concerns.

At this inspection we found this regulation had not been met. Although people told us they felt safe and were supported by care staff to safely mobilise around their home with equipment we found risks to people were not always appropriately assessed or managed.

People who received support with their mobility said they felt safe. One person told us that care staff always made sure they had their Zimmer frame with them prior to them mobilising around the home and one relative told us care staff supported their relative safely when using a hoist to transfer them. Staff knew the risks to people and records and documents confirmed they had received manual handling training to assist them to support people correctly. However, staff confirmed that risk assessments were not always completed prior to the commencement of care. One said, "They (people) might not have had a risk assessment done if it's an emergency start. Nine out of 10 times you get the information you need."

Risk assessments had been completed but contained insufficient information on how to manage and minimise the identified risks. For example, one person's mobility risk assessment detailed that a hazard to them was that they were independently mobile, this was rated with a high degree of risk score and the evidence of the risk was recorded as "Zimmer frame". It was unclear why the person being independently mobile was at risk and the Zimmer frame would have mitigated this risk rather than be evidence of a risk. There was no mention in the person's care plan they required the use of a Zimmer frame. This person's care needs assessment completed by external professionals prior to them commencing with the service stated they were at high risk of falls. This information was not documented on the person's mobility risk assessment or included in their care plan.

Another person's mobility risk assessment documented they "sometimes struggles with transfers." Records showed this as a high risk, however; did not include any further details regarding the reasons for why the person struggled with transfers and how to support this person safely with their transfers. This information was not included in the person's care plan. The person's care plan said they could manage transfers themselves.

Risks to people were not safely managed. Upon commencement with the service one person's care needs assessment identified they were independent with transfers and required the use of a zimmer frame to mobilise around the home. The person's care plan stated they required to be checked for pressure ulcers. We saw a body map dated three months after the person had commenced with the service which showed

the person had developed three pressure ulcers on their body. Also present in this person's care plan folder was an undated document completed by a senior manager detailing a visit which had taken place and highlighting the concern. It stated the person's skin had broken on three areas of their body and "It was impossible to change or wash (person) safely due to [persons] limited mobility and lack of equipment." The senior manager had alerted the appropriate external professionals following their visit; however, the person's risk assessment did not reflect this change in their mobility and there was no follow up or outcome from the external professionals visit. This meant risks to people were not appropriately managed to avoid harm to them.

A failure to appropriately assess the risks to the health and safety of the service user and doing all that is reasonably practicable to mitigate any such risks is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People may not be protected from harm or potential abuse because safeguarding concerns were not always reported or investigated in line with national policy. Staff knew the signs and symptoms to look for when people may be at risk of potential abuse and knew who to report their concerns to. However, prior to the inspection we received some concerning information from the local authority safeguarding team that they were not always informed of safeguarding concerns by the service. Records demonstrated that of the 12 safeguarding concerns raised the service had not informed the local authority safeguarding teams of two of these concerns. One of the two safeguarding concerns was under investigation by external authorities. Records showed the registered manager had been made aware of this concern by a relative and had investigated the concern independently from the local authority safeguarding team. The registered manager said they did not know they had to inform the local authority. It is a requirement of the Hampshire, Isle of Wight, Portsmouth and Southampton Safeguarding Adults Multi- Agency Policy that providers disclose and raise safeguarding concerns with the relevant local authority.

A failure to establish and operate effective systems and processes to prevent abuse of people was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection in November 2016 we found staff's fitness for work had not been assessed. We found this to be a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to send us an action plan telling us how they would meet this regulation. Following the inspection the provider sent us information which said they had taken immediate action to address our concerns.

At this inspection we found this regulation had not been met because the recruitment policy was not followed, applicant's fitness to work was not always assessed, gaps in employment history and reasons for them leaving previous employment had not been explored and references were not collected.

The registered manager said they had created a new fitness to work form and all existing and new applicants had completed this form. The registered manager confirmed only two applicants had remained with the service since the last inspection in November 2016. We looked at these two staff recruitment records and found a fitness to work form was only present in one staff member's records. However, the recruitment process was not completed in full for both new staff members. Gaps in their employment history and reasons for leaving their previous employment were not checked and only one reference was received for one of the staff members. The providers recruitment policy revised in July 2017 stated, "Two job references or one working and one character reference will be taken up for the prime candidate(s)." "The Agency may also require suitable candidates to undergo a medical examination prior to taking up an appointment."

Disclosure and Barring Service checks (DBS) had been undertaken prior to staff starting work. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Failure to operate an effective recruitment procedure was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and schedule 3 of the Health and Social Care Act 2008.

Although people experienced missed and late visits which impacted on their well-being, there were enough staff to meet people's needs. Staff confirmed there were sufficient staffing levels, however; this was impacted during times of unplanned absence when people's care visits would be later than planned or the staff member felt rushed. The registered manager told us that office staff would provide care visits when staffing levels fell below the required standards to ensure people received their care.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in November 2016 we found staff training was not always effective because the registered manager's knowledge of the subjects they trained staff on was lacking. Staff received an induction programme but their understanding and competency was not checked.
Although staff received a yearly appraisal; staff did not receive an effective supervision to support them to carry out their duties. We found this to be a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to send us an action plan telling us how they would meet this regulation. Following the inspection the provider sent us information which said they had taken immediate action to address our concerns.

At this inspection we found this regulation had not been met because sufficient improvements had not been made with meeting this regulation. The registered manager confirmed they had ceased providing the training for staff and as a result all training was provided by an external training provider. Staff confirmed they had received regular training and new care staff had completed an induction programme in line with the Care Certificate. The Care Certificate gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

However, people and their relatives told us they did not feel care staff always had the competency, skills and knowledge to care for them or their relative. Relatives told us they did not feel care staff supported people with dementia very well. For example, relatives felt care staff did not know how to deal with their relatives especially when they refused support with washing or eating. One relative said, "They just didn't help with those things and left." Another relative said, "Some don't seem to understand dementia very well, they don't understand that [my relative] might say yes that [they have] eaten when [they haven't] because [they] can't remember. They [staff] take it as read and will then leave without [person] having had any food."

A recent safeguarding concern highlighted poor communication and a lack of care between care staff and a person when personal care was being provided to them. This person had a diagnosis of dementia and care staff did not interact in a positive way with them because they did not know how to manage this person's behaviour when the person responded to being communicated with.

Records showed staff had received training in dementia, however; records did not evidence staff had their competencies checked following the completion of this training, other training or their induction programme. Staff and records confirmed they had received a supervision or appraisal. However, this meant although staff received training and supervision, the training courses and supervision meetings did not provide staff with sufficient knowledge and skills to support people effectively.

A failure to provide appropriate supervision and training to enable staff to carry out their duties effectively was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection in November 2016 we found consent was not always sought when people lacked capacity. Capacity assessments had not been completed for people who lacked capacity to consent to their care and people were not involved in the development of their care plan when they lacked capacity. Staff and the registered manager could not demonstrate a good understanding of how the Mental Capacity Act was used in their role. We found this to be a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to send us an action plan telling us how they would meet this regulation. Following the inspection the provider sent us information which said they had taken immediate action to address our concerns.

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

At this inspection we found this regulation had been met. Staff and the registered manager demonstrated an improved knowledge of how to support people who lacked capacity to consent to their care and support people to make decisions relating to their care. One staff member said, "Need to support them to make safe decisions and in their best interests. You have to presume capacity unless you know otherwise." Records demonstrated people who lacked capacity were involved in and consented to the development of their care plans.

At our previous inspection in November 2016 we found people were not always supported sufficiently to have enough to eat and drink because records did not accurately detail the support people required and the risks associated with this. We found this to be a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to send us an action plan telling us how they would meet this regulation. Following the inspection the provider sent us information which said they had taken immediate action to address our concerns.

At this inspection we found this regulation had been met. People did not raise any concerns or require support with eating or drinking and staff confirmed they would support people with this when required. Records demonstrated this support.

For those people who required support to access healthcare services care staff would contact the office or family member and advise of any concerns and whether a health care professional would need to be contacted. If necessary care staff would assist people with booking appointments if they were unable to do so independently. Care staff said they monitored people's health and wellbeing when they were supporting them with their personal care. Family members or people themselves would mostly be involved in contacting healthcare professionals when they or their relative required assistance. One person said, "The physiotherapists do come to see me every so often. I see a doctor every six months." Another said, "I do make my own doctors' appointments."

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us they and their relatives were involved in the assessment of their needs, development of their care plan and was involved in making daily decisions about their care requirements. Care plans reflected people's preferences, how they would like to receive support and what they were able to complete themselves. For example, one said, "I will have a full strip wash and I will do as much as I can manage. I will use a grab rail to stand. I like to keep as much independence as possible."

Staff confirmed they would respect people's dignity and privacy, support people to be independent with their care and said they would always involve people in their care and respect their decisions. One staff member told us how they involved a person in their care although they remained in bed. Another staff member said, "All the time. We treat everyone as an individual. Personalised care is really important. Everyone has a different way that they like to be cared for." A third member of staff said, "We encourage everyone to do as much as they can for themselves. I'll wait and have patience to see if they can do it. It's a huge thing for them and it encourages them to do it again. It might be quicker for me to do it but I'd rather wait 5 or 10 minutes for them to do it even if it takes longer." However, although care staff knew how to respect peoples dignity, they felt communication could improve between the office and themselves, particularly in times of grief and sadness. One staff member told us they had been sent to visit a person without being informed by the office that they had passed away, even though the family had informed the office. The staff member said, "The family were mortified."

When we asked people and their relatives if they received care from staff who were kind and caring and respected people's privacy and dignity, we received a mixed response and the following comments. "It is not perfect but it is good," "They are very caring people. They treat me well and they will always listen to what I say to them. They will never do anything without asking me or checking to see that I am happy," "Most of them are kind and caring, really, really friendly, they are respectful and we go through the care all together. There is nothing I don't like. Have got used to the [staff] now and we have a laugh and a banter.," "Most have a caring approach and are dignified when they give care." "Experienced carers are more caring; they are more understanding of [person's] needs. The newer ones are not very compassionate or dignified; they don't seem to have enough training," "My personal space and dignity are respected all the time." and "Yes I feel that my personal dignity is respected all the time, for example when they get me in and out of bed, wash me and dress me up."

However, a recent safeguarding concern demonstrated care staff were not always kind, caring, compassionate or respectful when supporting people with their care and did not always involve people with their personal care. The concern showed care staff were rough and heavy handed with the person. They did not communicate or engage with the person when completing care tasks, did not check with the person if they wanted or were ready for the care task to be performed, did not support the person to remain independent by allowing them to be involved in their care and did not maintain their dignity whilst being supported with personal care.

We received similar concerns to the safeguarding concern when we spoke with two relatives. One relative

told us care staff were, "In and out a bit quick." As a result their relative did not know the care staff very well because they had not developed a rapport with them during this time. The person's relative told us care staff did not "initiate chat" or "try to get to know [the person]." They told us as a result of the care staff not developing a rapport with the person they would become agitated and confused. They said the care staff did not reassure [the person] when this happened. They told us this mostly happened during the evening visit which meant the person went to bed unsettled. The person's relative said they had tried to communicate this to the manager but that it had not been addressed.

Another relative told us communication was poor between care staff and their relative. They told us their relative had informed them that staff had refused to prepare them a meal of their choice. There was no evidence in the daily communication sheet that this support was provided. The relative said, "As it stands it just seems that they didn't bother. Communication could be better."

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in November 2016 we found assessments of need were not always completed prior to the commencement of care. Care plans contained insufficient detail regarding people's preferences, choice, wishes and risks and the information in the care plans were not always accurate. People were not always involved in their care planning. We found this to be a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to send us an action plan telling us how they would meet this regulation. Following the inspection the provider sent us information which said they had taken immediate action to address our concerns.

At this inspection we found this regulation had been met. Records demonstrated people's care plans contained their preferences, choice and wishes. People confirmed they had a care plan and were involved in the development of this plan. One person said, "All I know is they do from time to time talk to me about my care. They go through my plan with me." Another said, "They have always worked with me on my care plan and everything is just fine." Records demonstrated care plans had been recently updated although did not include the identified risks to people.

People experienced late, rushed and missed visits. One person told us, "One day they (care staff) did not turn up but then we managed." One relative told us how their relative had struggled with completing their care because care staff had not "turned up." Documents sent to staff evidenced that there had been previous concerns relating to missed visits.

People and their relatives felt the care people received could improve because it was not always responsive to people's needs. One relative said, "Care is adequate; there is room for improvement. Feel needs are met but they seem to scrape by, it is what I expect as a minimum but they could go further. Just seems like a tick box exercise." Another relative told us how attendance times could be inconsistent they said, "We have asked for an early visit but we get visits at 09.30am and it has been 11.30am. We don't get a reassurance call if this is the case. [Relative] just ends up waiting and worrying." A third relative told us carers were often late and would not notify their relative which increased the persons agitation and caused them to worry that they had been forgotten.

One person told us how care staff did not know their care requirements had been increased and the time needed had increased. As a result, care staff turned up for a 15 minute visit when 30 minutes had been arranged. Other comments received about the lack of responsiveness of service delivery were, "The carers seem to take it as they could do less and leave after 10 minutes instead of the half an hour they should have been there for." "Staff go through the motions, they seem rushed." "I'd like more consistency and reliability to prevent my relative from becoming agitated." "They try to get in and out in the shortest possible time." People and their relatives who had been in contact with the office found the office staff were brusque and dismissive about their concerns.

There was a failure to operate assessable systems for identifying, receiving, recording and handling complaints. It was unclear how many complaints had been received into the service because complaints

and safeguarding concerns were completed on the same forms, labelled complaint forms. These records did not always identify the actions taken by the service in relation to the complaint.

Most people and their relatives said they had not had to complain about the service. Information on how to complain was provided to people within their care plans. However, for those people or relatives who had raised a complaint or concern, they felt their complaints and concerns had not always been dealt with to their satisfaction. One relative said, "Management don't seem to deal with concerns." Another relative said, "One evening they (staff) were late, I rang and rang the office and couldn't get through, I gave up in the end."

A failure to operate an effective and accessible system for identifying, receiving, recording, handling and responding to complaints by people was 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

At our previous inspection in November 2016 we found audits had not been completed of people's care plans and risk assessments and as a result we found people's care records did not contain all the information required to meet their needs and keep them safe. There were shortfalls in record keeping in a number of areas which had an impact on the quality and safety of support people had received. Systems to assess the overall quality of the service were not always in place. Complaints were received and incidents and accidents occurred and were reported. However, there were no systems in place to analyse the complaints, Incidents and accidents. The provider had not submitted their Provider Information Return (PIR) when requested and the Commission had not been notified of safeguarding concerns. We found this to be a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Following the inspection the provider told us they had taken action to address this concern.

At this inspection we found this regulation had not been met. A PIR, (this is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make), had not been requested to be completed by the provider for this inspection. Audits had been implemented to assess the overall quality and safety of the service but they were not always accurate or effective to improve the quality of the service and mitigate risks to people.

Audits to monitor the overall safety of the service had been implemented. However, these audits were not always effective and did not always lead to an improvement of service. For example, an analysis of the concerns raised, missed visits and accidents which had occurred each month were completed. We reviewed the audits for each month from December 2016 to end of June 2017 and found the information contained within the audits was not always accurate with regards to other records viewed. For example, the audits identified that the total number of concerns raised with the service between December 2016 and end of June 2017 were 107. The registered manager said they viewed concerns as complaints, however; the complaints folder did not contain this amount of concerns and there was no evidence of how these concerns had been dealt with.

The audits between December 2016 and June 2017 also identified that a total of four accidents had occurred within the service. However; the incidents and accidents folder contained details of eight incidents which had occurred between December 2016 and June 2017. The registered manager confirmed they counted incidents as accidents also. The audits did not take account of medicines errors which had occurred within the service.

Surveys had been sent to people in December 2016 to assess the overall quality of the service. Results of the survey had been collated and analysed, which identified areas for improvement, such as the overall satisfaction with people's care, times of visits and insufficient staffing levels. Action plans were not in place to address these areas for improvement and it was unclear what action had been taken to address these areas. At the time of the inspection people were still experiencing difficulties with their overall level of care, times of visits, rushed, late and missed visits.

We have reported in other domains of the report about shortfalls in record keeping in a number of areas which has had an impact on the quality and safety of support people have received. For example, risk assessments were not always completed prior to the commencement of care and did not contain sufficient information to support people safely. People's medicines were not managed or disposed of safely. Following the inspection we contacted the registered manager about the concerns we had found with the disposal and management of people's medicines. The response received evidenced that the registered manager was not aware of the issues raised and did not follow effective monitoring processes in relation to people's medicines.

Policies implemented to ensure the service delivered safe care were not always followed. For example, recruitment processes were not always followed by staff or the registered manager in line with the provider's recruitment policy. The disposal and safe management of people's medicines did not follow the providers "Supervising medicines policy" and national policies where not always adhered to when dealing with and investigating safeguarding concerns. As a result people were at risk of receiving an unsafe service.

A failure to have effective systems and processes in place to monitor and mitigate risks to people and maintain an accurate, complete record in respect of each service user and staff member was a continued breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection in November 2016 we found safeguarding concerns had been received into the service and were dealt with in line with the provider's policy; however, the Commission had not been notified of these safeguarding concerns. We found this to be a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We asked the provider to send us an action plan telling us how they would meet this regulation. Following the inspection the provider sent us information which said they had taken immediate action to address our concerns.

At this inspection we found this regulation had not been met. Although the Commission had been notified of the safeguarding concerns which had been received into the service, the Commission had not always been notified of these safeguarding concerns without delay. The Commission had been notified of 12 safeguarding concerns and there was a delay in reporting 10 safeguarding concerns to the Commission. These delays ranged from four days to three weeks.

A failure to notify the Commission without delay of any abuse or allegation of abuse in relation to a person was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The rating from the previous inspection in November 2017 had been clearly displayed in the front office of the service; however, the rating had not been displayed on the website. There was a website and when checked said it was under redevelopment and asked people to visit the site again soon. There was no evidence the rating had been displayed on this web page and there was no link to the Commissions website address. We spoke with the registered manager who told us the website had been under redevelopment since January 2017; they said they "had not had time to sort out." They told us staff and clients did not use the website and this was the reason they had not taken action to resolve this issue. Letters had been sent to people informing them of the outcome of the last inspection and contained details on how people could request or gain access to the published report.

The failure to display the rating on the website is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff members said they felt mostly supported by the senior managers and acknowledged the registered

manager was approachable but did not have a lot to do with them. One staff member said, "I don't have an awful lot to do with [registered manager] directly." Staff felt communication could improve between them and the office and confirmed they had never attended a team meeting or received praise from the registered manager or senior managers. One staff member said, "We don't get much thanks. All the staff will tell you that." Another staff member said, "We don't have actual staff meetings."

People and their relatives felt management were not very organised and were "haphazard," did not communicate very well when discussing people's care over the telephone or by email and had a poor attitude when speaking with them. One relative said, "When I have called they have been brusque, brief, like I'm wasting their time, too busy to talk, not the most welcoming." Another relative said, "Management are not very organised, if I ring I get the impression that they want to get rid of me, they are not listening to me properly that they have more important things to do than talk to me, it's very frustrating, the experience is not very pleasant." One person told us they felt there was "room for improvement with the office staff."