Torch Healthcare Services Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 14 and 19 June 2018 and was announced. This was the first inspection for this service since it was registered in March 2017. Torch Healthcare Services is a domiciliary care agency covering areas in and around Salisbury and Warminster. It provides personal care to people living in their own houses and flats in the community. It provides a service to people living with dementia, mental health, older people, learning disability, physical disability, sensory impairment and younger adults.

Not everyone using Torch Healthcare Services received regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

There was a registered manager in post. 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. In January 2018 the provider had appointed a new manager who was also in the process of becoming registered. The new manager was working alongside the registered manager.

Medicines were not managed safely. People's medicines administration records did not have the detail required to record what medicines had been administered. Staff had not been trained to administer medicines and their competence had not been assessed.

Staff were not recruited safely. The necessary pre-employment recruitment checks had not been completed. The service had not obtained a full employment history or checked gaps in employment. References from previous employers had not always been obtained.

Risks had not always been identified or assessed so that safety measures could be put in place. Where risk assessments had been completed, the service was not consistently working to safe practice they had identified.

There were not sufficient staff deployed to cover the care packages that had been agreed. The service recognised this and was in the process of handing back some contracts to the local authority.

Staff had not always been trained or supervised effectively. New staff had not had an induction to prepare them for their role. The registered manager had organised some online training which they were encouraging staff to complete.

Care plans were not detailed enough to guide staff to provide people with personalised care. Where people had specific health needs there was no guidance for staff to know what to do if the person became unwell.

Daily notes were not always written legibly. We were not able to read some entries in people's daily notes. We showed them to the registered manager who also could not decipher some entries. Within the daily notes we saw staff had recorded incidents and accidents but there were no incident forms completed. Due to the lack of systems for recording incidents this did not enable the registered manager to investigate. This meant the registered manager had not taken the appropriate action following all incidents and accidents.

Quality monitoring systems had not been established at the service. Due to the lack of monitoring in all areas the registered manager did not have an overview of quality or safety. This meant the registered manager was not aware of the shortfalls so they could make sure improvement was made.

People had not been asked for their views as reviews were not consistent. There was no established system or process to gather people's views using any other means such as surveys.

Staff we spoke with told us about the different types of abuse and the actions they would take to keep people safe. Safeguarding was discussed at team meetings and training was planned for all the staff to complete on safeguarding.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the systems in the service supported this practice. The service worked within the principles of the Mental Capacity Act 2005 (MCA).

People told us they were happy with their care workers. They told us they were treated with kindness and respect. Dignity was maintained when people received personal care and their property was respected.

Staff followed infection prevention and control good practice. They had access to personal protective equipment such as gloves and aprons, and people told us they used it.

Where meal support was provided, people told us they were given choice and support that was not rushed. People's needs in relation to eating and drinking were recorded with guidance for staff on how to provide care and support.

Complaints were investigated and findings recorded. Letters of apology had been sent where the service had deemed it was required.

Staff told us they felt the registered manager was approachable. They were aware that some areas required improvement and were confident the service would improve.

We found five breaches of Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report. Full information about CQC regulatory response to the more serious 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 safely. Medicine administration records did not contain all the information required to administer medicines safely. Staff had not been trained to administer medicines.

Recruitment checks were not robust to make sure staff were safe to work with people. There were not sufficient staff to make sure care packages could be consistently met.

Risks had not always been identified or assessed and managed so that people and staff were safe. Accidents and incidents were not always appropriately recorded and reported to the management.

Staff we spoke with knew the different types of abuse and the signs to indicate concern.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not always trained and supported to make sure they were able to do their job effectively.

People consented to their care and support and the service worked within the principles of the Mental Capacity Act 2005 (MCA).

Healthcare professionals were involved in people's care where appropriate as the service had made timely referrals.

Where people had support to help them to eat and drink, this was unhurried.

Is the service caring?

Requires Improvement

The service was not always caring.

Staffing arrangements had impacted on consistency of care

provided.

People told us they liked the staff that visited them and were treated with kindness. They told us staff respected them and their property.

The service tried to match people to care workers depending on gender and cultural backgrounds.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not have the necessary information to guide staff to be able to provide personalised care and support.

Some records had other people's names in which were clearly visible.

Complaints were recorded and responded to according to the provider's policy.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality monitoring systems were not established so the registered manager was not fully aware of the shortfalls found.

Risks to staff had not been assessed. Some staff were working long hours and in areas where there was no mobile phone coverage. There were not robust safety measures in place to support staff safety.

Feedback had not been sought from people to improve the service.

Team meetings had been held and minutes produced. Staff told us they felt supported by the registered manager.

The service worked in partnership with other agencies to make sure people received appropriate care and support.

Torch Healthcare Services 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 14 and 19 June 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

The inspection was completed by one inspector and an expert by experience spoke with people on the telephone to gain feedback about the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection, we reviewed the information we held about the service. Due to technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection we spoke with four people, the registered manager, the new manager, two care coordinators and three members of staff. We contacted four healthcare professionals and received a response from one. We looked at care plans for six people, medicines administration records, risk assessments, staff recruitment files and other records relating to the management of the service.

Following our site visit we asked the provider to send us confirmation of recruitment checks for one member of staff and training and rotas for another member of staff.

Inadequate

Is the service safe?

Our findings

Medicines were not managed safely. Not all staff had received training on medicine administration and competence checks had not been completed. This meant the service could not be confident staff had sufficient knowledge and skills to be able to administer medicines safely. The registered manager told us they were a trained nurse and talked staff through the process of administering medicines. They had not observed staff to check their practical skills. The registered manager was not aware of the NICE guidelines 'Managing medicines for adults receiving social care in the community'. These guidelines state that staff who administer medicines must have appropriate training and have assessment of their competence.

People's medicines administration records (MAR) did not have the required detail so staff could record what medicines had been administered accurately. People's medicines were written on the MAR but there was no route or dose recorded. The registered manager told us most people had 'dosette boxes' prepared by a pharmacist. 'Dosette boxes' are tools to help people manage their medicines. Providers are required to maintain an accurate record of medicines administered to people even where 'dosette boxes' are used.

Handwritten entries had not been signed or dated. We found many handwritten notes on the MAR indicating that medicines had been stopped, changed or started. Staff had not dated the entries, or signed them. When staff write handwritten entries on people's MAR, best practice is to sign each entry and date it to confirm the information recorded. NICE guidelines state that changes to MAR should only be made and checked by staff who are trained and assessed as competent. This practice reduces the risks of transcribing errors.

There were unexplained gaps on some people's MAR which the registered manager was not aware of. We found one person had many gaps on their MAR for all of their medicines. The registered manager thought some gaps were due to the person being in hospital, they were not sure about the others. We asked them to investigate this during our inspection. One person had recorded in their care plan that they were allergic to paracetamol and aspirin. This information was not recorded on their MAR. The NICE guidelines state what information should be recorded on people's MAR. Known allergies should be recorded.

Risks to people's safety had not always been assessed so that safety measures could be put in place. One person was using bed rails on their bed to prevent them from falling. The use of bed rails had not been risk assessed to keep the person safe. There was no guidance for staff to inform them where the bed rails should be placed on their bed or how to use them safely. People can become trapped in bed rails if they are not placed in the correct position and used correctly. The Medicines and Healthcare Products Regulatory Agency have published guidance on the safe use of bed rails which was not available to staff.

Risk assessments had not always been dated to record the date the risk had been identified and the safety measures put in place. For example, one person required a wheelchair to mobilise and hoisting equipment to transfer. Their mobility risk assessment had no date recorded. This meant the service could not be sure the assessment of the risks was the most up to date. Where the risk assessment contained guidance on safety measures these were not being followed. One person had a mobility risk assessment that stated they required two members of staff to assist them to move. This had been reviewed in April 2018 so was current.

We noted in this person's daily notes that one member of staff was supporting this person to move during the night. We raised this with the registered manager who told us the member of staff was only changing the person's continence aids. The daily notes recorded that the member of staff was supporting the person with their personal care and to change position every night. We asked the registered manager to review this care package.

Accidents and incidents had not always been reported to the management and an incident form had not always been completed. This meant the management had not been able to investigate the cause of injury to prevent reoccurrence or report to the local safeguarding authority if needed. For example, we saw that one person had written in their daily notes that staff had noticed some 'lacerations on their thigh'. The staff member had written the 'lacerations had not been there the day before'. We asked the registered manager to investigate this without delay.

Visits to people had been completed by staff who had not been recruited appropriately or trained. A new member of staff had recently been appointed. The registered manager told us they were in the process of completing pre- employment checks prior to them starting employment. We saw in one person's daily notes this member of staff had completed a visit to a person on their own. We asked the registered manager about this. They were not aware this had happened. This meant that a person had been visited by a member of staff who did not have all of the required recruitment checks in place and no induction. We saw they had shadowed a more experienced member of staff the day before so they could be introduced to the person but his practice was not safe. The registered manager gave us assurances this member of staff would not do any further visits to people alone.

The above areas are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe Care and Treatment.

Staff had not always been recruited safely. Full employment histories had not always been obtained, and gaps in employment had not been explored. References from previous employers had not always been sought. The provider had not always completed a Disclosure and Barring (DBS) check. The DBS carry out a criminal record and barring check on people who have made an application to work with adults who may be at risk. This helps employers to make safer recruiting decisions and helps prevent unsuitable staff from working with people. The provider had copies of DBS checks that previous employers had completed but there was no risk assessment in place to support the decision not to obtain their own DBS check. Two DBS checks completed by other employers were done in 2014. Whilst there is no requirement to renew a DBS check, accepting a certificate from 2014 was not safe practice. Our guidance on DBS checks recommends that DBS certificates from other employers can be accepted if they were completed within three months of the employees application date.

The provider had not checked that staff were physically and mentally fit to carry out the care worker role. Where staff had worked in a care role previously the service had not checked the reason why the employment had ended. The provider had not completed 'Right to work' checks as per the government's guidance to make sure employees were able to work in the UK. Employers should check all job applicants' right to work documents. Original documents must be seen, verified and the date must be recorded on all copies taken. The provider could not demonstrate these checks had been done. For two members of staff we saw their documents had been emailed to the service. All documents should be checked with the applicant present.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Fit and proper persons employed.

There were insufficient staff to meet the care packages agreed. The service had recruited some staff on a self-employment basis. This meant that staff worked for themselves but under the umbrella of the agency. Staff could take time off when they wanted and work the hours that they chose to. This had proved difficult for the service to manage to make sure people had consistency of care.

This year the service had employed its own care workers to start to make a transition towards only employing their own staff. This meant the service struggled to cover their visits. Two staff who had worked full time had left the service which had created vacancies the service was struggling to fill. The registered manager explained that they recognised this shortfall and had begun the process of handing back some contracts to the local authority.

We noted in one person's daily notes that one member of staff had supported them at night for a number of consecutive nights. We raised this with the registered manager, as we noted they had worked most nights in May and June 2018 alone. We were told this was because no other staff trained to support this person's specific health need would work nights. This was not safe. Staff need to have sufficient breaks in order to rest and there must be sufficient staff to meet people's needs.

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

Despite the shortfalls in risk management and staff, people we spoke with told us they felt safe. Comments included, "Yes I feel safe, they [staff] are patient, they give me time", "I feel safe, it's the way they help me" and "Absolutely I feel safe. It's their kindness, gentleness. Better than others I've had."

Staff were provided with personal protective equipment (PPE) such as gloves and aprons. Staff we spoke with told us how they followed infection prevention and control good practice such as washing their hands. People told us the staff used PPE. Comments included, "They have gloves and aprons and they are very good at washing their hands", "They wash their hands every five minutes" and "They don't wear uniforms, they supply gloves and wear them."

Staff we spoke with could tell us different types of abuse and signs that would indicate concerns. Staff told us they would report any concerns but had not received any formal training in safeguarding. The service had made some referrals to the local safeguarding team when they were concerned about people.

Requires Improvement

Is the service effective?

Our findings

Staff had not been trained effectively for their roles. Staff had been shown by Occupational Therapist's how to use equipment if it was needed in people's homes but some staff had received no other moving and handling training. The service was supporting people who were at risk of developing pressure ulcers. The staff had received no training on how to identify if skin was damaged or what care and support people would need. The registered manager recognised that the service had not provided sufficient training to date. They said they had introduced an online system, so staff could do training required. Staff we spoke with told us they needed training.

New staff had not had an effective induction. Staff could shadow a more experienced member of staff for a few days to meet people and observe their practice. This had been the only part of the induction process. Training had not been provided and there was no structure to staff induction. One of the care co-ordinators had completed the Care Certificate. The care certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of the job role. It covers 15 standards, which include communication, privacy and dignity, duty of care and safeguarding. This had not been provided to care workers. The new manager told us they had recently developed a formal induction process to include the Care Certificate which new staff would complete. As new staff starting would be shadowing agency staff it was important that they had a formal induction process to prepare them to work for Torch Healthcare Services.

Staff had not always had the opportunity to have supervision. This is a process where staff meet 1-1 with their line manager to discuss a range of topics such as training needs, concerns or development needs. Since the new manager had started in January 2018 we saw they had made a start on providing supervision for staff. They recognised this was an area that required improvement. Despite these shortfalls staff we spoke with told us they felt supported.

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

People we spoke with told us they thought staff understood their needs. One person told us, "Yes, they [staff] do understand my needs. The carers call the GP when I need him. They pick up quickly when they know I'm not feeling so good." Another person told us, "They absolutely understand my needs. I think the carers would pick up quickly if I was not well. I had a 'turn' the other day, they made me tea and came back later to make sure I was ok."

People were assessed prior to the service being received. The registered manager completed all the assessments. Where possible the service obtained information from the local authority about the person's needs and wishes. The local authority assessments were stored in people's files.

People could access healthcare professionals when needed and appropriate. Records demonstrated that the service worked with district nurses, dieticians and OT's to make sure people got the healthcare support

they needed. One person needed to use a specific piece of equipment to mobilise. The service had liaised with the OT about how best to support this person safely. One person required a percutaneous endoscopic gastrostomy (PEG) feeding tube. This was a tube, which had been passed into the person's stomach through the abdominal wall. People have PEG for many different reasons, but mainly it is because people are not able to eat or drink orally. Records demonstrated that the nutritionist had been involved in assessing the person's needs and contributed to their care plan.

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. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. For this type of service, applications to deprive people of their liberty must be made to the Court of Protection. The service was working within the principles of the MCA.

Records demonstrated that staff were checking for consent to care prior to supporting people. Where people had made a decision not to have help and support this decision had been respected. The service had not completed any formal mental capacity assessments and best interest meetings to date. They were not supporting anyone who required this level of support. We discussed the process with the management who told us if needed they would apply the principles of the MCA.

As part of care packages, people could have support with their meal preparation and meal times. The support offered ranged from meal preparation to heating up a meal in the person's microwave. People told us they had sufficient time to enjoy their meal and they were not rushed. Support required was recorded in people's care plans. One person who used a wheelchair could only see the lower shelves of their fridge. Staff had recognised this and it was written in the their care plan to only place food on the lower shelf, so the person could easily see what food they had. One person said, "They prepare my food for me. They do it in the way I like things. I am not hurried."

Requires Improvement

Is the service caring?

Our findings

Due to the staffing arrangements at the service we were not confident the service could consistently provide the care and support agreed. Records demonstrated that people had experienced late visits or missed calls. This had caused distress. One person who lived alone did not receive their visit until 11pm one evening. They used a wheelchair and needed staff to support them to go to bed. The registered manager told us this call was missed due to "confusion" between the member of staff and the office. The registered manager was alerted to this missed call and attended to the person themselves.

There had been further confusion in communication between management and staff which had resulted in a person being told their visits were stopping. This had caused concern for the person and their healthcare professional who had organised the care package. Whilst the management clarified that the service was not going to stop without notice this had caused a period of unnecessary anxiety for the person.

Supervision records and team meeting minutes demonstrated that staff were concerned about the lack of staff. Staff we spoke with told us they were working "flat out" and on their days off to cover people's visits. Staff usually had a small group of people that they visited regularly. This enabled people the opportunity to get to know their care workers well. However, staff were often covering other workers so visiting people they did not know. Management were aware of the shortfalls and were in the process of recruiting new staff.

Despite the inconsistency of staff supporting them people we spoke with told us they were happy with the staff that visited them. Comments included, "They are all so lovely", "They [staff] are very, very pleasant. They are kind, I'm very fond of them", "They are very good", "They are just like family" and "I just can't fault them". One person told us, "I'm getting on very well. Each one of them [staff] does something I'm happy with."

People thought the staff respected their property whilst they were supporting them. Comments included, "I think they respect my property. They always ask if I'm happy", "They leave the house tidy" and "They absolutely respect my property. They worked around some building work I've recently had done to my house."

Staff treated people with kindness and people thought their dignity was maintained during their visits. One person told us, "They are kind, caring and respectful. They would do anything for me." Another person said, "They [staff] are gentle kind and very loving." One person told us, "They [staff] definitely keep my dignity. They keep me covered, doors and curtains are closed." Another person said, "They keep me covered and keep my dignity when getting me up in the morning." Staff told us ways in which they promoted dignity. They told us they made sure doors were closed, curtains were closed and that people were covered during personal care.

People had a choice of male or female care workers. The registered manager told us people's preferences were explored during the initial assessment and recorded in their support plan. One person told us, "I don't mind male or female carers. I have men some days, ladies on others. I don't mind."

Where possible, the service tried to match care workers with people who shared the same interests or culture. The new manager told us about one person who was from an African country. They were able to find a care worker who spoke the same language as the person. The person preferred a male care worker which was provided. The manager told us this match had resulted in good outcomes for the person. The care worker could support them to cook food they enjoyed in addition to being able to speak in their first language. One person told us, "I am well matched with my carers. They are comfortable with me. They know what I need."

The manager told us they aimed to only provide 30 minute or above visits to people. They currently had one 15-minute visit but it was to a person they visited four times during the day. The manager told us they wanted people to have time during their visits to talk to the staff. One of the aims of the service was to support people to combat loneliness. By making sure people had time to talk to their care workers would help to reduce any feelings of isolation.

People's confidential information was stored safely and only accessed by authorised staff. People's care plans were stored in their homes so they could access them at any time.

Requires Improvement

Is the service responsive?

Our findings

People had a care and support plan in place which recorded their needs in a range of areas such as personal care, eating and drinking and moving and handling. We found that not all plans were detailed enough to give staff guidance on how to provide personalised care. As the service was using a high number of agency staff we had concerns that they would not know what care was needed and how it was to be delivered.

Where people had specific health needs, there was not always sufficient guidance for staff to follow. For example, one person's needs assessment recorded that they had diabetes. There was no guidance for staff to know how best to support this person to manage their diabetes. There was no reference to diabetes in any part of their care plan. The provider could not be sure that staff would know how to respond should the person become unwell. The person also had a skin complaint. There was no guidance for staff to know how to support this person. Within their daily notes we saw that staff were 'applying creams'. There was no detail on what creams were to be applied and where.

Within one person's daily notes we saw they had a 'bandage' which the care workers had recorded needed changing. Within the person's care plan there was no reference to any reason why the person required a bandage or wound dressing. The registered manager told us that this person was also supported daily by the district nurses. Their nursing records were kept at the person's home so the details of any wounds and their treatment would be recorded in their notes. However, the service cannot rely on district nursing notes as they may be removed at any time. People's health and social care needs should be identified, assessed and documented in their care plans.

People's records did not always demonstrate respect for the person. For example, we observed in a person's care plan that another person's name had been written on it and crossed out. For another person we saw another person's name was clearly visible.

The service had not reviewed the care and support for some people. Where reviews had taken place, we were not able to see that people and/or their relatives had been able to be involved in the process. The registered manager told us people were involved but they could not demonstrate any systems in place to support this. One person's care plan had no date to indicate when it was created. There was no records to demonstrate the service had reviewed the person's needs or support. Another person's care plan had been created in July 2017. They had not yet had a review of their care. This meant that the provider could not be sure care plans contained current information for staff to follow. No care plans had been signed as agreed by individuals or their representatives.

We saw in the care records for two people that care workers had recorded they were feeling pain. One person was experiencing pain on two consecutive visits on the same day. Whilst recording this, staff had not documented what they had done in response. This meant the person may have experienced pain for many hours without need. The registered manager was not aware of these entries in the daily notes. We asked them to look into this without delay.

We saw that for some people their communication needs were recorded in their care and support plans, however this was not consistent. For example, one person had been assessed as having 'limited hearing and vision'. The care plan said they had 'aids'. The local authority assessment for this person indicated that they were 'blind in one eye and losing their sight in the other eye'. This assessment gave a clearer and more robust indication of the person's needs. This person also had a hearing impairment. Even with the two assessments of this person's needs there was no guidance for staff in the care plan about how to communicate with this person.

These areas are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Person-centred care.

Some care plans had been written in a positive and person-centred way. There was also a breakdown and step by step guidance for some visits. This gave staff a good indication of what each visit consisted of and what the person wanted. We saw that one person used a mobile telephone and an electronic tablet. These items needed to be within their reach which was documented in their care plan. The need to maintain dignity had been written into the step by step guidance. This gave staff a prompt to greet people by their preferred name, to not talk over the person and to be sensitive to the person's circumstances.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The provider had not considered providing people with a disability or sensory loss information in a format accessible to them.

Where specific equipment was needed, the person's plan contained guidance on how to use it. For example, one person required a ceiling tracking hoist. There was guidance from the manufacturer on how to use this safely, guidance on what sling to use and on what setting.

The service managed complaints responsively. Records demonstrated that complaints had been recorded and managed according to the provider's procedure. There were some occasions when visits to people had been late or unable to be provided. The service had received a complaint about this which they had documented. There was a letter of apology to the person explaining why the error had occurred. The new manager had on two occasions met with the person and/ or their family to discuss their concerns in person.

There was nobody receiving end of life care at this time. The registered manager told us they did try to discuss this with people and make sure their wishes were recorded. We saw two people had made a decision not to be resuscitated. This was recorded in their care plan. It was also recorded where this document was in the person's home and the importance of making sure it accompanied them at all times.

Requires Improvement

Is the service well-led?

Our findings

This was the first inspection since Torch Healthcare Services was registered in March 2017. They commenced providing care and support to people in July 2017.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was also the nominated individual and a registered nurse. In January 2018 the service had recruited an additional manager who was in the process of becoming registered.

Quality monitoring systems had not yet been established at the service. The new manager had recognised this was a shortfall so had employed a consultant to undertake some visits with staff and report on their findings. An audit of some recruitment files had taken place and identified some of the shortfalls we found. However, there was no action plan to identify what action was needed and by whom. There were no other quality and safety checks being completed. This meant the provider did not have a clear picture of the improvement that was required in any area. For example, audits of people's MARs would have identified gaps in administration so that this could be investigated.

There was inconsistent monitoring of practice to make sure people were safe and being cared for according to their wishes. Accidents and incidents were not monitored to identify patterns and trends. People's daily notes were not monitored so that shortfalls could be identified at the earliest possible opportunity. Many daily notes we reviewed were illegible in parts. This meant we were not able to read what had been recorded. We showed this to the registered manager who also struggled to clarify what was being documented. People's records must be accurate, complete and legible in order that there is a contemporaneous record of care delivered.

There was no contingency planning for staff shortages. The provider had not assessed and monitored the risks that may arise from staff working consistently high numbers of hours. One member of staff had worked over 300 hours in May 2018. The provider could not demonstrate that the risks associated with working consistently without rest breaks had been mitigated.

The service operated in some rural parts of Wiltshire where there was no mobile telephone signal. Staff were expected to use their own mobile phones. This had not been risk assessed so safety measures could be put in place to keep staff safe in the areas outside of network coverage. Management had not completed lone working risk assessments. We could see the subject of lone working was an item on the agenda of a team meeting so the potential risks had been discussed. Whilst lone working had been discussed with staff, information to identify and address the risks was not in place. The new manager told us they had requested the provider buy staff mobile phones to use whilst out on visits. This would enable the agency to assess mobile phone coverage for all the team and put in place safety measures where needed.

The service had not sought feedback from people or their relatives on the service provided. The new manager had recognised this shortfall and produced a formal survey which they planned to use to gain feedback.

These shortfalls are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Good governance.

Safeguarding referrals had been made to the local authority. We had not been notified of these incidents. We discussed this with the registered manager during our inspection. They believed they had emailed notifications to us. They had used the wrong email address. It is the provider's legal responsibility to notify us of specific incidents without delay. We asked the provider to submit notifications following our inspection which they have done.

The provider and management were open and transparent about the improvement that was required. The provider recognised that the new manager was needed due to their knowledge about managing a service that was working within the regulatory framework. Despite the shortfalls in the service, the staff we spoke with enjoyed working for the agency. They told us that they recognised the company had "teething problems" and was trying to improve the shortfalls. One member of staff told us, "Torch has the makings of a good company. I really enjoy working for them and find everyone approachable."

There was a staff structure with clear responsibilities which had been recently produced. The registered manager had introduced an additional level of management. They told us they had recognised staff required additional support and guidance. In order for them to do this they had introduced a care-coordinator role. There were two employed to support two teams of staff based in Warminster and Salisbury.

Staff told us they felt supported by the management at the service. They told us the registered manager was on hand to provide advice, guidance or support. They could tell us what the values for the service were and all said the registered manager was passionate about providing good care. One member of staff told us, "[registered manager] is so enthusiastic about providing good care, I feel it." Another member of staff said, "I feel valued as a carer, they listen to me." People had met the registered manager and told us they thought the service was well run. One person told us, "The managers have been around. The service is well run and very approachable."

Team meetings had been held and minutes produced. Staff told us they worked as part of a good team. One member of staff told us, "It is a fabulous team, we communicate with each other all the time." Minutes recorded discussions with staff about training they needed to complete, care plans, lone working and staff shortages.

At the time of the inspection, the service did not have an administrator at the office. This had an impact on people, relatives, professionals and staff being able to contact someone when needed. The registered manager had planned interviews the day after the inspection to recruit an administrator. They recognised this would help them improve communication with people and record keeping.

The service worked in partnership with various agencies. Records demonstrated they worked with the local authority social care teams and healthcare agencies. One healthcare professional told us, "I have an excellent working relationship with the registered manager. They are managing an incredibly challenging case very well. We have done joint planning visits, which has helped to manage a complex situation."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care and support was not planned to reflect their personal and identified needs. Records kept were not always person-centred.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were no effective systems or processes to assess, monitor and improve the quality and safety of the service. Feedback on the service had not been sought from people and/or their relatives. The provider had not assessed, monitored and put into place contingency plans to make sure staff were not working consistently without rest.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not always been suitably trained to make sure they could carry out their roles effectively. Staff had not been able to have regular supervision to support them in their role. New staff had not had an effective induction. There were not sufficient numbers of staff deployed to keep people safe.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely. Incidents and accidents were not always reported to management so that appropriate action could be taken. Risks to people and staff had not always been identified or assessed so that suitable safety measures could be put in place.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff had not been recruited safely. The provider had not ensured the necessary checks had been completed to make sure fit and proper persons were employed.

The enforcement action we took:

Warning notice