Health Care Resourcing Group Limited

CRG Homecare - Hammersmith

Inspection report

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Date of inspection visit:
22 January 2019
23 January 2019
24 January 2019
25 January 2019

Date of publication:
25 March 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this unannounced inspection on the 22, 23, 24 and 25 January 2019. CRG Homecare-Hammersmith is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community and provides a service to older adults and younger adults living with disabilities. At the time of our inspection the service was providing care to 336 people in the London Boroughs of Hammersmith and Fulham and Kensington and Chelsea. Services in these boroughs were operated by two separate branches which both operated from this location.

Not everyone using this service receives 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.

We last inspected this service in July 2018 where we found breaches of regulations concerning the management of medicines, good governance and staffing. We served three warning notices against the provider. We carried out this comprehensive inspection to see whether the provider had met these notices.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our inspection the provider was in the process of recruiting a new manager, and the two branches were overseen by area managers.

There were increased visits and phone calls to check that people were happy with how their care had been delivered. When people made complaints these were not always fully addressed, and sometimes the response to complaints was extremely poor.

Risks to people's safety were assessed, but some issues of risk were not fully addressed. At times management plans were generic and did not meet people's individual needs.

Safeguarding procedures were not followed and there were insufficient recording and checking of financial records to protect people from potential loss or abuse. There were safer processes in place for recruiting staff but these were not always followed.

People's experiences of the service had improved since the last inspection. There was improved consultation with people using the service and improved supervision and oversight of staff. People reported improved punctuality and reliability of care workers but the overall performance had not improved. There was a lack of consistent management and supervisory staff sometimes lacked the training to effectively manage care workers.

People told us that their care met their needs. Some care plans had not been reviewed although people's

needs had changed. People described their care workers as kind and patient, and told us they always felt safe when their care workers visited.

At the previous inspection we found that medicines management was not always safe. There had been improvements to how medicines were managed. This included more audits being carried out and increased oversight of care workers when errors had taken place. However, there were still times when audits had not picked up on issues of concern.

At the previous inspection we had found that sometimes people did not receive care from two care workers when this was required. The provider had implemented dedicated rounds where care workers now travelled in pairs. This had lead to an improvement, but a small number of calls remained where care workers did not appear to have worked in pairs.

We have made a recommendation about how the provider presents information in accessible formats.

We found four breaches of regulations relating to safe care and treatment, safeguarding adults, good governance and the management of complaints. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Aspects of the service were not safe.

Safeguarding procedures were not always followed when allegations of abuse had been made.

Risks to people's safety were assessed but did not always fully address these risks.

Safer recruitment processes were not always followed. There had been improvements in ensuring two care workers arrived for calls when this was required.

Is the service effective?

Good

The service was effective.

Care workers received the right training to carry out their roles and had regular supervisions. Sometimes supervisors lacked the training to ensure that supervisions were effective.

People received the right support to maintain good health and to eat and drink well.

People consented to their care, and where people lacked capacity to do so the provider ensured they worked in people's best interests.

Is the service caring?

Good

The service was caring.

People and their relatives spoke of being supported by kind and patient care workers who took the time to speak with them. People spoke of being listened to and their dignity being upheld.

People's plans included information on how best to communicate with them.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive.

At times reviews were ineffective and a small number of plans had not been updated to reflect changing needs.

Complaints were not always fully addressed and sometimes the response to complaints was exceptionally poor.

People told us their care workers met their needs and people were supported in line with their care plans.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was a lack of consistent management in the service.

Managers had acted to address many concerns about the service and there was improved engagement with people using the service.

Systems of audits and checks had improved but sometimes failed to address issues of concern.

Scheduling was poor and there had been no improvement to punctuality. People found it difficult to contact the office at weekends.

CRG Homecare - Hammersmith

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.

Why we inspected- we carried out this comprehensive inspection as we had previously served warning notices against the provider for breaches of three regulations. Since the last inspection we had maintained contact with commissioning services in both boroughs where the service operated and attended provider concerns meetings.

Prior to carrying out this inspection we reviewed records of these meetings and reviewed the provider's action plan. We looked at records of important events that the provider is required to tell us about.

We were aware of concerns about this service. This included receiving one complaint from a member of the public and information from members of staff which was shared with us anonymously. We had informed the local authorities of these concerns to be investigated. We were aware of four allegations of missed visits and three allegations of financial abuse.

The inspection took place between on the 22, 23, 24 and 25 January 2019 and was unannounced. One adult social care inspector and a pharmacy inspector attended on the first day and on the second day four inspectors attended. On the third day two inspectors and an assistant inspector attended and two inspectors attended on the final day. On the last two days the team included two Experts by Experience. An Expert by Experience is a person with experience of using health and social care services.

We looked at records of care and support for 20 people who used the service, medicines administration records and care plans for nine people and records of recruitment and supervision for 10 care workers. We

also looked at records of audit, training and other records related to how the service was managed, including electronic call monitoring and rota information. We spoke with two area managers, the provider's director of quality and care, two care co-ordinators and four care workers. We spoke with 16 people who used the service and five relatives of people who used the service.

Requires Improvement

Is the service safe?

Our findings

Following our last inspection we issued a warning notice regarding staffing. This was because for several people who required two care workers to support them, there were multiple occasions where the two care workers were present together only for a few minutes, or at times were not present together at all.

At this inspection, we found the provider had met this warning notice. People reported clear improvements. Comments included, "There always needs to be two of them and there always are", "There are enough now, they turn up in two's, "There has to be two with him and for four-five months now this has been consistent" and "They know to turn up at the same time and it is very rare that that doesn't happen."

The provider told us that where possible they had allocated people to teams of care workers who routinely worked in pairs. Where people were part of these rounds care was delivered as planned. Where people were not part of these rounds there was still improvement but the issue persisted in a small number of calls. For one person there was a single morning call where it appeared care workers had not been in the person's house at the same time. For another person there were three occasions during the day where care was not delivered in pairs as planned, but this person was not usually hoisted at this time. The provider was not aware of this issue, but had since introduced alerts on the electronic call monitoring system which would detect this.

At our last inspection we issued a warning notice regarding safe care and treatment. This was because medicines were not managed safely.

At this inspection we found the provider had met this warning notice and was now meeting this regulation. However, we identified some areas where practice needed to improve.

The provider had a medicines policy. Medicines were prescribed by individual GPs and usually delivered to people using the service by local pharmacies. Care workers administered medicines from multi-compartment compliance aids or original packs. Medicines administration record (MAR) charts were computer generated by a trained senior staff member and counter signed by another staff member. Care workers signed MAR charts to provide assurance that this was completed. Allergies were documented on MAR charts which meant that care workers had access to this information at the point of medicines administration.

All care workers received medicines training and were assessed as competent before being allowed to administer medicines.

There had been an overall improvement in the recording of medicines, but at times issues continued. Staff conducted MAR chart audits and identified some issues; however, we saw that not all issues were being picked up through the audit process. Sometimes audits were carried out several weeks, or even months after the MAR chart was completed. Two charts had many blank spaces and had not been audited at all.

Sometimes error rates appeared high. For example, one care worker had been identified as having made 55 errors in a month, but in practice every medicine not signed for was counted as an individual error. When a person took six tablets in an afternoon and this was not signed for, this was considered to be six errors. The provider had carried out competency assessments and discussions when errors had taken place. These discussions had been effective for some care workers, but for others this had not resulted in obvious improvements in practice.

There was a system for documenting medicines errors and incidents. We saw evidence of medicines audit follow up actions such as additional training of care workers or re-assessment of their competency, but this was not always effective. Learning from medicines errors was also shared in team meetings with other staff.

Care workers were providing medicines support and monitoring when it was not properly documented in the care plan. This was contrary to both the provider's policy and national guidance. The provider told us that they had been working with the local authority to address this as they felt that referral information did not always reflect a person's level of medicines support. Some MARs did not always have enough detail for staff to provide medicines support safely and effectively. One person was self-administering their own insulin. The medicines record was not clear on what the dose of insulin should have been, and what type of insulin the person was taking. However, care workers were signing to say that they had 'prompted' the person to take the insulin. The provider was not able to provide assurance that this person's insulin was managed appropriately.

We were not assured that a medicine for the management of Parkinson's disease was administered at the same time each day as far as practical and possible. This was because the MAR chart did not specify what time of the day it was supposed to be given.

We saw an example of a person with a medicines care plan, medicines passport and a MAR chart. The medicines listed on all three records were different. Therefore, we were not assured that there was an accurate list of medicines that the person was taking. The same person was having insulin injections. However, there was insufficient detail in the records relating to the insulin being taken.

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

Everyone we spoke with told us that they felt safe using the service. Comments included, "I feel very safe, they care for me so well" and "We have no concerns, the regular carers we have are nice". However, despite people's positive comments we found some aspects of the service were not safe.

People were not safeguarded from abuse as safeguarding procedures were not followed. For example, when an allegation of financial abuse was raised against a member of staff, this staff member was not suspended but moved into an administrative role. Despite this, they had still been allocated to attend some calls whilst the investigation continued. This investigation had also been hampered by a care co-ordinator interviewing the alleged victim despite this being subject to a police investigation. In another case, two members of staff had been suspended following an allegation of financial abuse. One member of staff had been permitted to return to work as the provider had concluded they could not have been involved, but there was no risk assessment carried out of this or consultation with the safeguarding team or police about this decision.

Following one of these allegations, the provider reminded all care workers of the financial recording policy. Despite this, we saw evidence that this was not always followed. For three people just one care worker signed for transactions they had carried out on behalf of people, even though the person was not able to

check or countersign these transactions. In other cases, recording sheets contained errors and either had not been audited or auditors had not picked up on these errors. This lack of oversight put people using the service and staff at risk.

This constituted a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us that staff carried out care in a safe way. Comments included, "They tell me what they are doing like one, two, three lift" and "They manage [my family member] well."

The provider carried out assessments of risks to people's safety and wellbeing. These included risks from moving and handling, falls and those relating to people's environments. Moving and handling plans contained suitable instructions for how to do this safely, but assessors did not always record that they had checked that equipment had been suitably checked and serviced. There were risk assessments to check that people using bed rails were not at risk of entrapment. In some areas risk assessments did not fully address risks to people. One person's needs had significantly changed and they were now receiving support from two care workers to make transfers, but there was no risk assessment in place for this. Another person was smoking in bed, and used a skin cream, but the provider had not assessed whether there were risks associated with this or recorded what this cream was and whether it was flammable.

The provider had a system for assessing the risk to people of skin breakdown and pressure sores. This included scoring people's risk around factors such as age, continence, weight and mobility. Where people had pressure sores these were monitored by staff with the support of district nursing teams and people's skin integrity had improved with support.

However, risk management plans for skin integrity were generic and did not always fit people's needs. Depending on whether the risk was identified as low, medium or high, the plan had a set list of management steps for care workers to follow. Some of these steps were not followed, such as reviewing the plan quarterly or recording repositioning on a dedicated chart, but it was not always clear that these steps were needed. When people were routinely repositioned, this was not always recorded in daily logs or checked by managers.

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

The provider had safer recruitment processes in place, but at times these were not fully completed. The provider obtained proof of identification, a work history and sought references from previous employers. Two of 10 staff files had an unexplained gap in employment and for one staff member the provider had failed to obtain evidence of satisfactory conduct in previous health and social care roles.

The provider carried out checks with the Disclosure and Barring Service (DBS) before care workers started work, as required by law. The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions. However, the provider's policy was unclear on how often these needed to be repeated. It was a requirement of the provider's contract with the local authority that these be renewed every 12 months, but this was not always taking place.

Everyone we spoke with told us that their care workers observed good infection control practice. One relative said, "They use gloves when they change him/her and aprons, those plastic ones. They throw them away straight away. I don't worry about infections and spreading germs as they are very good and explain

why they do it."

Where incidents had occurred they had been dealt with either under the safeguarding, medicines or complaints procedure. We found that learning from these incidents varied depending on what procedure these were addressed under. For example, medicines errors were follow up with care workers, but safeguarding procedures were sometimes not followed and the response to complaints was sometimes poor.

Good

Is the service effective?

Our findings

People told us their care workers appeared to have the knowledge and skills to support them. Comments included, "They seem very well trained", "The carers we get seem very good, efficient and knowledgeable. They work hard" and "They seem well trained and they enjoy what they are doing." Care workers told us they received sufficient training. Comments from staff included, "You are always learning" and "We get trainings as and when we need it."

New care workers received an induction in line with the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should be covered if a staff member is 'new to care' and should form part of a robust induction programme. Care workers received annual training in key areas to carry out their roles. This included manual handling, basic life support, health and safety, dementia awareness, fluids and nutrition and infection control.

Care workers received supervision every three months. Supervisions were used to discuss people's care plans, dignity, choice and control, record keeping and staff development and training needs. Where concerns were identified actions were usually recorded.

At times supervisions were not effective and front-line managers lacked the skills and training to improve staff performance. In several cases supervisors had raised with care workers that their punctuality needed to improve, however there was no attempt to set targets or to develop a clear improvement plan with care workers, or to monitor whether this was effective. In some cases, management was limited to '[care worker] was asked to be on time'. Similarly, many competency discussions had taken place with care workers following medicines errors and issues with recording, but these did not always lead to improvement.

The provider told us that they had not previously had dedicated training for front line managers, but that they were working to put together a training programme to address this.

People and their relatives were positive about the help they received to eat and drink. Comments from people included, "When I first had them I wasn't eating hot meals so much and they didn't offer to help with food. Now they write down for me if I've had something so I don't forget and help by cooking hot food" and "[My care worker] bought me a special cup to help keep my drinks warm when she isn't there." Comments from relatives included, "They make sure [my family member] drinks his/her special milk drinks because he/she doesn't drink them for me. They sit with him/her and coax him/her. They are good and very calm" and "They called me when the meals weren't delivered and running low so I could deal with it".

People told us the service met their health needs. One person told us, "I get the help and medication I need on time". Where a person with diabetes was clearly unwell this had been suitably followed up by care workers, including prompting the person to check their blood sugar level and to seek medical advice. Guidance in place for staff was very generic, and there was no clear guidance on how best to support the individual.

People told us they were involved in decisions about their care. A person using the service told us, "I make decisions about how I like them to do things". Comments from relatives included "[my family member] is involved in decisions about what she wants to do and how they help her" and "The carer we have always involves [my family member] which makes her feel like she is still listened to."

The provider worked in line with the Mental Capacity Act 2005 (MCA). The Act 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. Where the provider thought people lacked capacity, staff carried out detailed assessments to assess this, and were able to use this process to identify when people did have capacity to make certain decisions. Where it was concluded that people did not have this capacity the provider met with relatives in order to make decisions in people's best interests.

Good

Is the service caring?

Our findings

People and their relatives told us that their care workers were kind and caring. Comments included, "I like them and especially my main one, she has empathy", "I feel that they respect us as a family using their service. I feel he/she is looked after well and the carer treats him/her as being important", "They are very pleasant and I do look forward to a little chat" and "They are very patient, I find this really caring as [my family member] can be difficult with them."

Some comments indicated that there had been improvements in this area. These included, "I think they have had a big sort out of staff because they used to be awful but now we are happy", and "I am happy with the carers… There was only one carer once who was snappy – I called her 'bossy boots' – she doesn't come anymore."

Three people told us that sometimes their irregular care workers were less engaged and knowledgeable. Comments included, "It's the relief ones that you sometimes get that don't have much time to listen or chat. They do respect his/her privacy and dignity but they don't do much else", "The odd one is a bit rushed and doesn't have much time for you. I think they are emergency carers" and "I really struggled with the carer yesterday. The person could not cook properly and complained she had to do two hours cleaning. She did not do my laundry properly."

Everyone we spoke with felt listened to. Comments included, "I feel they listen to me and give me time to answer any questions", "I think they listen to my wishes" and "I tell them what I think. Sometimes I think they think I am wrong but they still agree with me unless it is something that is going to hurt me or cause harm."

Care plans included basic information about people's religious needs and whether they practiced or had special dietary needs. Plans also included information about factors which may upset a person or cause them anxiety, including people's social interaction and how the provider could best support this. There was useful information on how best to communicate with a person, including when a person's condition meant it was best for care workers not to ask what the person wanted for lunch, but to offer a range of foods. Plans also highlighted when care workers should announce their arrival to avoid startling the person.

Plans included a section on how people expressed their sexuality, but in practice this was about describing the clothes people preferred to wear during the day and night and it did not link to a person's sexuality.

People spoke of their cultural needs being respected. Comments included, "I have a male carer wherever possible as I asked for this. They respect that I have times I like to be alone to pray and they do not come in this time. I feel respected", "I requested no male carers as I am a woman and they stick to this. My wishes are met" and "They respect our family ways and our home."

People told us they were treated with dignity and that care workers respected their privacy. Comments from people included, "I feel I still have my dignity and I'm listened to", "Privacy is as good as it can be and they do ask if they can assist with dressing and toilet trips. I feel I have dignity" and "It is a very dignified service."

Care workers we spoke with demonstrated a good knowledge of how to uphold people's dignity.

Requires Improvement

Is the service responsive?

Our findings

People told us they were able to complain. Comments included, "Whenever I've needed them I've called and they have helped me straight away" and "I called the office twice. Once was a few months ago and they helped me and gave me the information over the phone straight away. The first time they didn't call me back for a few days and I was worried."

There was a process in place for addressing complaints. However, sometimes the response to complaints was extremely poor. In some cases, the staff member addressing the complaint had entirely misunderstood the nature of the complaint, and at times had apologised whilst simultaneously denying any responsibility. In another case the provider had acknowledged a person's complaint but felt that this no longer needed to be explored as the person was no longer using the service.

Some responses were poorly written and sometimes nonsensical. At times in letters to people and their families, the person using the service had been referred to as "SU" or even by their reference numbers. One letter was even addressed to a person by their reference number. One letter read, 'If the complaint has been…upheld, list the corrective or preventative actions to be taken'. Another stated, 'We hope that we have now resolved your concerns to your greatest satisfactory and you will accept our apologies', even though none had been offered.

The provider told us that there had been insufficient oversight of the member of staff responsible for responding to complaints, and after the inspection showed us evidence that they were reopening all complaints addressed by this member of staff.

This constituted a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Everyone we spoke with told us their needs were met by the service. Comments included, "My needs are met and they ask me what I feel I need", "My needs are being met and I am happy with this" and "[My family member] gets all the help he/she needs from them and they do assist him/her well. It's very centred on him/her and we are very happy with that."

People told us they had care plans which clearly indicated what their needs were and what care workers had to do to meet these. Notes from care workers indicated that in most cases people had their needs met in line with their care plans. We found two instances where people's needs had changed but their plans had not been reviewed to reflect this.

Where people's plans were reviewed, supervisors used the opportunity to assess whether people were happy with their care. However, these did not always take place regularly or explore whether people's care plans still met their needs or whether anything needed to change. At times quarterly review processes were not followed properly, and focussed on repeating information which was in the care plan, rather than whether this was still relevant to the person.

The provider was not meeting the Accessible Information Standard (AIS). There was a policy in place for how the provider should flag up when people required information in a format applicable to them, but in practice assessments did not include this information. We saw an example of an accessible support plan which the provider was completing. However, this included limited information on how information should be presented to the person and it was not clear that the person could understand the mostly text-based content. The accessible version of the plan was 62 pages long and contained over 4,000 words. The plan stated that the person understood a language other than English, but it was not clear whether they needed information presented to them in this language.

We recommend the provider take advice from a reputable source on following best practice for meeting the information and communication support needs of people who use services.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we issued a warning notice about the governance of this service. This was because actions were not taken when audits identified problems with the service and punctuality was poor. The provider had not fully met this notice because although audit had improved, there had been no improvements to the punctuality of care workers.

The service had suffered from a lack of consistent management. There had been three branch managers overseeing the Hammersmith branch in two years and this post was currently vacant. It is a requirement of the provider's registration that a registered manager is in place, but this was not the case. The service had been overseen by an area manager who had left shortly after our previous inspection. At the time of this inspection the two branches were overseen by two regional directors, one of whom left their post shortly after this inspection. Another new manager and regional director had been appointed who were due to start in March 2019.

People's experiences of the service were generally positive. Most people using the Hammersmith and Fulham branch had no general complaints about the service, with most issues of concern raised by people who were supported by the Kensington and Chelsea branch. Several people spoke of recent improvements to the service. Comments included, "Things have improved in the last few months and if it continues it will be great. The quality of the carers is much better and the office seem more efficient", and "I find it has improved a lot in the last few months."

Most people were positive about the management of the service. Comments included, "They never used to answer the phone if you called to ask questions or complain to the office but now they call you back if you have left a message and quickly too. The service has improved", "I don't know the manager personally but the office staff seem friendly and approachable" and "Generally speaking I can get through to the office on the phone."

Four people we spoke with expressed concern about contacting the office, especially at weekends. Comments included, "I think the agency is disorganised; it takes ages to get through on the phone", "Saturdays and Sundays are diabolical. I have never come across such a chaotic arrangement in my life. You ring and ring and they don't answer" and "There are big problems getting through on the phone. At the weekend it is almost impossible."

There had been limited attempts by managers to improve punctuality but sometimes these were ineffective. For example, when care workers were often late for their calls this was discussed with them in supervision, but there was no target set for this or any real plan for how this could be addressed effectively. Some care workers had also been sent a letter to address poor punctuality and remind staff that their contract with the local authority required them to meet a target. However, this offered no suggestions about how it may be improved and misidentified the local authority and even the branch the care staff worked in. The provider told us "CRG introduced a zero tolerance for electronic call monitoring across the group because of the issues in London and they [we] also appointed an additional ECM operator to manage the alerts on the

system….[there are also] additional call handlers."

However, everyone we spoke with told us they felt they care workers arrived on time. Comments included, "For a few months now it has been very good, always on time and lovely people" and "She is usually on time." Some people expressed only minor concerns; "The traffic is bad at the time in the morning I need help but I understand and it's only five minutes. They are sometimes a bit unreliable on bank holidays or when a carer is on holiday." and, "They are always on time and the one time they weren't [my relative] got a call."

People told us their care workers stayed the whole time, and we confirmed this by checking call monitoring data. Comments included, "They stay their time. Sometimes if he is being tricky they stay a bit longer. This has massively improved as they used to do basics and rush out" and" They used to rush from me on to someone else but they take more time with me now. They used to tell me they were very short of staff but now they have more time."

In total punctuality had not improved significantly since our previous inspection. In the month of January 2019 39% of calls were delivered late. This compared with 38% of calls being late in June 2018. At our last inspection we found that care workers were late to their first call of the day 40% of the time. At this inspection there had been some improvement, but care workers were still late to their first call 20% of the time.

Staff did not have enough time to travel to many of their calls, which reflected the results of a recent staff survey. We looked at 11 care worker rotas over seven days, which covered 650 calls, and used a journey planner to see if care workers had enough time to travel between calls. We found that 51% of the time staff did not have enough time to arrive within 15 minutes of the planned time, and 24% of calls had so little travel time that care workers would arrive more than 45 minutes late. A small number of rotas were impossible to follow, for example one person's rota required them to start at 3:30am and attend 23 calls in the day, finishing at 9:45pm, with a 5am start scheduled for the next day, and this pattern to continue for three days. Another care worker was due to start at 6am or earlier and finish after 10pm for seven days, attending an average of 19 calls per day. Therefore we could not be assured that the provider's quality monitoring and governance systems were effective.

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

The provider told us they felt previous managers had expanded the service too quickly and that they lacked the capacity to support the number of people they currently did. The provider was in negotiations with the local authority and other providers to arrange to subcontract out some people's services and felt that this would lead to an overall improvement in the service. The provider told us that they intended to review rotas when this was complete and were evaluating technology that would help them to improve scheduling.

The provider had carried out a considerable number of additional spot checks, including visiting people at home to ensure that they were happy with the service that they received. Surveys had been carried out to find out the views of people using the service and the staff team.

There was increased audit of log books which had resulted in improved record keeping of the care people had received. Audits scored the quality of a book based on the answers to key questions, but there were flaws with this process. For example, equal weight was given to whether care workers had used black pen and whether there were any gaps in recording in the logs. There were times that use of coloured pen had been followed up with staff when this management time could have been more effectively used elsewhere.

Audits did not routinely consider whether care workers had met people's needs or whether changes may be needed to people's care or risk management plans.

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 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment were not provided in a safe way as the provider did not always assess risks to the health and safety of service users or do all that was reasonably practicable to mitigate such risks 12(2)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not operated effectively to prevent abuse of service users 13(2)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not always investigated and necessary and proportionate action was not taken in response to any failure identified by the complaint or investigation 16(1)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated effectively to assess, monitor and improve the quality and safety of services provided or to provide an accurate, complete and

contemporaneous record of the care provided to the service user with regards to medicines 17(1)(2)(a)(c)