

4USupport Limited

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Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service well-led?

Inadequate ●

Summary of findings

Overall summary

About the service

4 U Support is domiciliary care service providing personal care and support to people in the Plymouth area. There were 61 people receiving a service at the time of this inspection. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where personal care is provided we also consider any wider social care provided.

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

People's experience of using this service and what we found

The Care Quality Commission (CQC) and the local authority had received concerns from people receiving care from this service prior to this inspection, regarding poor training of staff, poor culture, lack of equipment, visit times not as expected and not having their concerns responded to.

Some people told us their visits were not always as expected. Fifteen out of 28 people reported to us that they had experienced visits not as planned. People told us "When I ring the office and say I'm not happy because the call times have been changed again, they say 'Sorry, it won't happen again'. But then it does happen again and again. It's very frustrating to say the least." Staff told us, "I have fed back concerns to the office. Nothing changes" and "We keep telling them, but it does not help." Relatives told us, "I have emailed them repeatedly and got no response at all" and "This morning the carers were an hour late. I've rung the office to complain, but I don't know if it's been passed on, or who it may have been passed on to, or what they might do about it. It's so frustrating because if I'd have known the call was going to be that late I'd have got (Person's name) ready myself. It's horrible for (Person's name) being stuck in bed waiting for ages. This isn't the first time it's happened."

Some relatives told us their family member did not always have their wishes respected when they had requested care staff of a specific gender. This was not always provided and led to people sending the male carers away and then trying to provide for the needs of others. This had impacted on the families, who lived with the person, who were often kept waiting for support.

The staff rota did not always provide adequate time for staff to travel from one person to another and arrive on time. Staff told us, "We get no travel time between visits, and so it is impossible for us to do the job properly and get to the next person when they expect us. If you do all that you are required to do you end up running late and working hours that you are not being paid for. I have told the office about this but nothing

changes."

The registered manager was aware of these concerns and had taken some action however, this had not been effective in resolving these issues and to bring about consistent improvements.

People told us staff mostly stayed for the agreed period of time for the visit when they arrived. However, we found the rota did not allow for staff to stay for the commissioned period of time and still arrive at the next visit as expected.

Staff told us the registered manager was not always available and they dealt with the office management team when necessary. Some staff reported good support from the office staff others told us there was 'animosity and chaos between the management team which impacted on the service.'

Due to the recent change in computer systems used at this service, the management team were not always able to provide information requested by CQC prior to this inspection. This was collated and provided the day after. This information showed the registered manager did not have effective oversight of staff training, supervision and appraisal, and staff had not completed training necessary for staff to carry out their role safely.

All the people we spoke with told us they received good care from the care staff who were kind and caring. Comments included, "I get very good care, the help that I get to get dressed is really good, they are all so caring, I have no problems with any of them." Relatives told us, "On her birthday they bought my mother presents and cards. The younger girls call her Granny, she loves that" and "They are always very friendly and obliging, they interact with Mum, make her feel at ease. They address her by her first name, they are like a family friend".

People's support plans did inform, direct or guide staff in what actions to take to meet their needs in the way they chose.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. For example, not respecting people's choice of gender of carer and not providing visits at the time agreed.

Systems had been implemented to help ensure the effective management of medicines. Some staff who were administering medication were provided with training and had their competencies checked to help ensure correct procedures were followed. However, not all staff had received training in medicines management.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update

The last rating for this service was requires improvement (published 21 November 2019).

At this inspection enough improvement had not been made and the provider was still in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections.

Why we inspected

The inspection was prompted in part due to concerns received about visits not made when expected, lack of necessary equipment, poor moving and handling practices, poor culture and poor responses from the management to concerns raised. A decision was made for us to inspect and examine those risks. As a result, we carried out a focused inspection to review the key questions of safe, effective and well-led only. We also reviewed the breaches of regulation from the last inspection.

We reviewed the information we held about the service. We requested additional information from the provider prior to the office visit. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 4U Support on our website at www.cqc.org.uk.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe
Details are in our safe findings below

Requires Improvement ●

Is the service effective?

The service was not always effective
Details are in our effective findings below

Requires Improvement ●

Is the service well-led?

The service was not well-led
Details are in our well-led findings below

Inadequate ●

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 was a focused inspection to check on specific concerns that had been reported to the Commission. We looked at the service's care records, recruitment practices, staffing arrangements, risk management systems, incident and complaints recording and review processes.

Inspection team

The inspection was carried out by a lead inspector 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.

Service and service type

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had two managers registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was announced. We announced the inspection several days in advance to ensure the registered manager would be available to participate in the inspection process and to make arrangements for information to be shared with the commission prior to the site visit. Due to the concerns raised people, their families and staff were all given the opportunity to speak with us if they wished. Before we visited the services office, we discussed infection control processes for people, staff and inspectors with reference to Covid 19.

What we did before the inspection

We reviewed information we had received about the service since the last inspection and the information we

had requested when the inspection was announced. We asked the service for information to be sent to the inspector regarding visit times, staff support, quality assurance audits, and Covid 19 policies. We used all this information to plan our inspection.

We had not requested the provider send us a provider information return as this inspection was completed in response to information of concern that the commission had received.

The inspection began on the 30 September when the service was advised of the inspection. Phone calls were made to people who received a service on the 2 October 2020. The office visit was made on 12 October 2020 due to the registered managers being away on holiday.

We spoke with 21 people who used the service on the telephone. We spoke with 15 relatives. We contacted seventeen staff of which nine responded to our phone calls. We also spoke to four health and social care professionals who worked with the service.

The lead inspector visited the office and met with the office administration team. We looked at computer held records such as visit times, risk assessments and staff support. We looked at four care records in relation to people who were being supported with a regulated activity. We reviewed recruitment files, accident and incident reports and complaints management processes.

After the inspection visit

We continued to seek clarification from the provider to validate the evidence found. We reviewed the additional documentation we had requested from the registered manager prior, during and after the site visit.



Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

At the last inspection this key question was rated as requires improvement. At this inspection we found not enough improvements have been made and the provider is still in breach of regulation.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

- At our last inspection the provider had failed to ensure staff had sufficient time for people's visits. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found a new computer system had been recently installed at the service, which recorded all visits made by staff to people's homes, care plans and staff support such as training. This new system had not led to people receiving their visits as agreed as no travel time was scheduled. Concerns continued to be raised about late calls as before.
- People were asked about their visit times and their views were mixed. 15 out of 28 people reported to us that they had experienced visits not as planned. For a few people the unreliability of arranged visit times was an issue. Comments included, "They never come at the time they are supposed to. Out of the last seven days they have been late three to four times. They are usually half an hour or later for visits.....I don't rely on them. It's a waste of time phoning the office" and "No, they are not on time, sometimes they are late, sometimes they are very early, and I am still in bed." Others told us, "It is very rare that they are late, if they are, I ring the controller and he will tell me if there has been an emergency," "They are mostly regular staff, the different ones are all nice," and "They used to be later than I wanted and needed. It's taken a while and some effort, but I've got the earlier times now, so I'm happy."
- Staff turnover was high. Relatives told us, "There is quite a turnover at the moment, the carers are not staying, they are losing all the experienced ones. The new ones are younger with no experience" and "They always seem short staffed." Staff confirmed they were leaving, some were leaving after many years of working for the service, they cited being exhausted and having no faith in the management team.
- Some staff rotas, sent to CQC, did not provide any travel time between care visits. Inadequate travel time was seen in most rotas. This meant it was not possible for staff to completed visits as planned and for the full duration. Staff told us, "We get no travel time between visits, and so it is impossible for us to do the job properly and get to the next person when they expect us. If you do all that you are required to do you end up running late and working hours that you are not being paid for. I told the office about this, but nothing changed". People told us, "When I ring the office and say I'm not happy because the call times have been changed again, they say 'Sorry, it won't happen again, but then it does happen again and again. It's very frustrating to say the least.'
- Relatives reported raising issues with the service and not receiving a satisfactory response. Comments included, "I have emailed them repeatedly and got no response at all" and "This morning the carers were an hour late. I've rung the office to complain, but I don't know if it's been passed on, or who it may have been passed on to, or what they might do about it. It's so frustrating because if I'd have known the call was going

to be that late I'd have got (Person's name) ready myself. It's horrible for (Person's name) being stuck in bed waiting for ages. This isn't the first time it's happened." Some people had specific conditions which required time specific visits from care staff. This was clearly recorded in their care plans. However, visits were not always made as planned and this did impact on family members as they were required to step in.

- Some people received the rota via an app and were satisfied that the information was mainly accurate. People told us, "I've got the app through Careline, so I get the rota that way. It's usually pretty accurate." Other people were not able to access this app and told us, "If I want to know who's coming the next day, I have to remember to ask the carer before they leave. Sometimes I forget and that's a nuisance," and "I never know who we're going to get from one day to the next. The weekends are the worst. It's just a shambles."

The failure of the provider to take effective action to ensure staff had sufficient time to carry out people's visits as agreed is a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Recruitment practices were in place and records showed appropriate checks were undertaken to help ensure the right staff were employed to keep people safe. Disclosure and Barring Service (DBS) checks and references were received before staff were able to visit people alone. People told us, "New staff are introduced to us and usually are accompanied by someone experienced" and, "This morning a girl who had not been before turned up, she introduced herself and was very professional."

Systems and processes to safeguard people from the risk of abuse

- Not all staff had completed safeguarding adults training. This meant that staff may not always recognise abuse and not be aware of the need for it to be reported. Please see the Effective section of this report for concerns regarding staff training.

The failure of the provider to ensure staff had the necessary skills to keep people safe, contributed to the breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- The Care Quality Commission had received a number of safeguarding concerns and whistleblowing reports prior to this inspection. These were about poor moving and handling practices, lack of necessary equipment, poor staff culture and lack of effective management response to concerns raised. The registered manager had been asked to look into these concerns and had investigated and responded stating they had not upheld most of the concerns and therefore the opportunity to change the organisation's practices and processes were missed.

- Most people told us they felt safe and comfortable with their care staff.

Preventing and controlling infection

- It was not possible to see, from the records available at the inspection visit, if all staff had received training on infection control. It was not shown on the list of necessary training provided. We relied on information collated for the inspector, by the registered manager, after the office visit, to judge if staff had received training in this area.

- The first report provided stated over half the staff had not completed training on infection control, despite working in the community during the Covid 19 pandemic. Upon seeking assurances from the registered manager that staff would receive this important training, additional evidence was submitted showing a quarter of the staff were still to complete this training.

The failure of the provider to ensure staff received necessary training contributed to a repeated breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Staff told us they were following the current Public Health England (PHE) guidance regarding the Covid-19 pandemic. Staff had access to personal protective clothing, (PPE) such as aprons and gloves to reduce cross infection risks. However, some staff told us they were restricted on the number of masks they were able to use during a shift.
- People told us staff wore personal protective equipment (PPE) and washed their hands frequently, comments included, "The service we get is safe as houses. I'm very impressed with everything they do now we've all got Covid to deal with. It can't be easy for the carers having to keep dressing up and washing their hands all the time."

Learning lessons when things go wrong

- The registered managers did not have an effective system for monitoring accidents and incidents. Whilst the registered manager was often aware of an event and investigated any issues raised to them, there was no formal process for recording and auditing such incidents. This meant the opportunity to further improve the service may have been missed

Assessing risk, safety monitoring and management

- We had reports of necessary equipment not being available. We were told this was due to equipment being broken and that once it had been identified it was replaced immediately.
- Risk assessments were in place in people's care plans. They guided and directed staff on how to reduce assessed risks. For example, what equipment to use to move a person safely.
- Staff were advised of any risks regarding the access to people's homes. For example, how to access the property and where to park safely.

Using medicines safely

- Some people told us they were supported with their medicines by care staff and received them on time. Other people administered their own or were assisted by family members. They told us, "I have pain killers for my arm and eye drops every morning, they are always on time to give them to me." However, other family members told us they had needed to take over the administration of some medicines due to staff arriving late for some visits.
- It was not possible to see, from the records available at the inspection visit, if all staff had received training on medicines management. We relied on information collated for the inspector, by office staff, after the office visit. This showed not all staff had been provided with this training.
- Medicine competency checks were seen in staff files. These were carried out to help ensure staff managed medicines safely.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- At the last inspection we made a recommendation that the provider reviews how they are assured staff are competent to meet everyone's needs, following their induction. At this inspection we identified additional issues in relation to staff skills and the provision of training
- Prior to this inspection CQC received repeated information of concern that some staff were not always moving and handling people in a safe manner. This had been previously reported to the registered manager for investigation, but the concerns continued to be raised by people and staff.
- It was not possible to establish accurately what training staff had received during the inspection visit.
- After the inspection had concluded, the registered manager sent training data to the inspector which confirmed necessary training had not been provided. One third of the staff team had not completed moving and handling training. This meant that the registered manager had not taken effective action to address the repeated concerns about the poor moving and handling practice of some staff, and some staff had still not been provided with necessary training.
- Information about staff training in infection control was also confusing. The first report provided by the registered manager stated over half the staff had not completed training on infection control, despite working in the community during the Covid 19 pandemic. Upon seeking assurances from the registered manager that staff would receive this important training, additional evidence was submitted showing a quarter of the staff were still to complete this training to improve safe practices.
- In addition, records were not available to demonstrate staff had received training in safeguarding adults.
- Some supervision was provided for staff by the management team. This provided an opportunity for staff to discuss any issues or training requirements. However, when asked the registered manager was unable to demonstrate how often this support had been provided to individual members of staff. There was no information on staff appraisals provided.

The failure of the provider to ensure all staff received appropriate support, training, supervision and appraisal, was a repeated breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Most people and relatives felt that the staff were knowledgeable and able to meet the needs of people they supported.
- New members of staff told us they completed an induction programme and the Care Certificate. This included shadowing experienced staff. Staff and people confirmed that spot checks of staff were completed.

Ensuring consent to care and treatment in line with law and guidance

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

- There was no information available to the inspector at the time of the office visit relating to necessary training of staff on this legislation. This meant it was not possible for the inspector to make a judgement on when training had taken place and when it may next be due. This information was collated by the office staff and provided after the office visit.
- From information provided after the visit, it was clear that not all staff had completed mandatory training on the Mental Capacity Act. This meant staff were not provided with necessary knowledge to help ensure people's rights were protected.

The failure of the provider to ensure staff had received necessary training contributed to the breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- At the time of the inspection not all people being supported by the service had the capacity to make their own decisions. However, staff understood the need to seek consent before providing care. People confirmed staff asked for their consent before commencing any care tasks.
- Staff had recently visited people in their homes to seek their signed consent to their care plan. This meant that people were aware of their own care plans.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Relatives told us, "They (management) are sending a lot of males, I won't have them. It has been going on for years. We had a man this morning. My wife will not have them touching her. She needs two carers, they send a woman and a man, they expect me to take the place of the man. It's a waste of time I send them away, we won't have males in the morning. I've stopped the lunch and teatime visits and am not even able to go out now. I have always been told that if I cancel them and then need them again I won't get them, it will be my own fault for stopping them," "I tell (Staff name) about my problems with male carers but it falls on deaf ears" and "They have been sending a few males recently. Me and my sisters are not happy about it. We told them we do not want a man giving our mum personal care, they said it was in the care plan that we signed in the very beginning. I spoke with (Staff name) about it but they are still sending men."
- People said they did feel able to speak to staff or managers about their concerns. However, as detailed in the well led section of this report, people did not always feel listened to, or that their wishes would be respected. Two relatives reported they had requested female only care staff for the person receiving care and that this had not always been respected. This had led to them sending male staff, who had been rostered to carry out the visit, away and not having the care and support as planned.

The failure of the provider to respect people's personal preferences was a breach of Regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- People's needs were assessed before they received support from the service. This helped ensure their needs could be met.
- Some staff training had been arranged to reflect the range of needs staff supported people with. For example, catheter care.

Supporting people to eat and drink enough to maintain a balanced diet

- Staff supported people with their meals and snacks. People told us this was completed according to their wishes.
- When people had specific routines or preferences, these were recorded in people's care plans. However, as evidenced in this report the timings of visits was not always according to people's preferences. One relative told us it had taken 'a lot of chasing' to get meals provided at time where medicines, such as insulin, depended on this.
- People told us that staff reheated microwave meals for them and provided them with hot drinks.
- Everyone reported that staff cleared up after themselves and left things clean and tidy.

Staff working with other agencies to provide consistent, effective, timely care

- 4U Support had recently implemented a new computer system application (app), People who were able to use the app or email were more satisfied with the running of the service than those who did not use the technology, especially around knowing which care workers would be coming and when. Some people had reported difficulty accessing the system and reported that the service had not assisted them with this.
- The service worked closely with commissioners and healthcare providers to help ensure people's needs were met. However, commissioners told us that they had received some concerns from people and their families around visit timings.
- Staff worked with professionals to help provide care to people. The service had recently taken on several new packages of care to support the pressures felt in the acute sector.

Supporting people to live healthier lives, access healthcare services and support

- Staff supported people to monitor their health and identify when they needed to contact a healthcare professional.
- If staff arrived to find a person unwell or injured, they would stay with the person until emergency assistance had arrived.

Is the service well-led?

Our findings

Is the service well-led? ☐

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- At our last inspection the provider's governance arrangements had failed to ensure risks were adequately assessed, monitored and mitigated. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider remained in breach of regulation 17.
- Many people and their relatives continued to be unhappy about their call times and consistency of familiar staff. This had been reported to the registered manager and CQC on a number of occasions. This concern had been raised in our 2018 and 2019 inspection reports.
- The new computer call monitoring system showed the times of all calls made. We asked for a report on visit times to be sent to CQC. This showed late visits were taking place regularly.
- We were told the new computer system prompted calls to people, one day in advance, telling them which carer would be visiting them the next day. People told us they were not always contacted with this information, if their visit was running late or about any changes to their regular carers.
- Quality assurance audits had been carried out during the week of this inspection. People told us they had been unexpectedly asked for their views on the service by the staff. They told us this had made some of them feel uncomfortable as they did not feel able to raise any issues or criticisms for fear of losing their carers or being thought of as 'difficult'. As detailed in this report many people had raised concerns repeatedly with no effective action taken, they had grown frustrated and irritated by this. Some told us they had been invited to find another agency to meet their needs.
- The registered managers had recently undertaken a survey of people's views related to their visit times. An action plan from the responses to this survey had been completed. However, these actions had not resolved the situation. This meant that the audit process was not effective and opportunities to improve the service had been missed.
- It was not clear if each of the two registered managers had separate responsibilities for different aspects of the running of the service. There were no effective systems in place to manage staff training needs. Staff training records were disorganised, inaccurate and difficult for the registered manager to access. This meant it was not possible for the registered managers to know when such support and training had taken place. Some staff reported good support from the office staff. Others told us there was 'animosity and chaos between the management team' which impacted on the service.

We found no evidence that people had been harmed. However, systems were either not in place, or robust

enough, to demonstrate effective and consistent management of people's visits and necessary staff support and training. This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and relatives had mixed views about the new app. Some told us they did not find the new computer system useful. They told us that the technology was not easy for them to use and felt that the new app was not helpful to them. One relative told us the new app was 'definitely not an improvement.'
- Comments about the new system were mixed. Many people and their families did not use new technology. People who were able to use the app or email were more satisfied with the running of the service than those who did not use the technology, especially around knowing which care workers would be coming and when. Relatives comments included, "I have not been able to access any records since the end of September. I have tried contacting the office repeatedly but there is no response. I have no way of knowing what is happening now" and "We used to get a letter every week telling us who would be coming and the times. We don't know who the next carer will be, we are waiting for the office to download an app for us".
- People did not feel involved in changes to their visits. They told us, "The time of our call can be changed by the office and I don't get to hear about it. We have a 7.50am call, but this week the carers came at 8.30am and told me they now had to fit another call in before us. No-one had told me about that." and "The times change day to day, so every day I have to ask what the times will be the next day. It's not easy to work round that and I think that's the worst thing we have to deal with."
- Staff felt they were not involved in the way the rota was planned and how the visits were managed. They told us, "We don't get travel time. The rota makes it look like the houses are right next door to each other, but they are not. Time travel would be needed to get there. We have mentioned this, but nothing is done" and "The management don't involve us when taking on a lot of new clients. They just keep taking on more and more and we just can't do it. They try to recruit new staff at the same time as taking on new people it was a car crash."

The failure of the provider to address effectively concerns that had been raised was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

- Following our last two inspections where we identified concerns with people not always receiving their visits at the agreed times, the registered manager sent us an action plan detailing how this would be addressed. We found at this inspection, as detailed in the safe section of this report, action taken had not been effective and people continued to be dissatisfied with the timings of their visits and lack of information about changes made. For example, one person would not recommend the service to others because of the poor organisation of call visits.
- Some people told us that they had been invited, by the management team, to find another provider if they were not happy with the service they received. People told us that this was not an easy option for them and so felt they had to 'put up with it.'
- The CQC had received concerns regarding poor moving and handling practices of staff in February, March, June and twice in September 2020. The registered manager had not taken effective action to address these repeated concerns.
- There was not an effective process in place for recording incidents and complaints received. The complaints file did not clearly show how issues had been resolved and when. There were no records available after July 2020. The CQC had passed many issues to the registered manager for investigation since

that date.

The failure of the provider to ensure visits were provided on time and to effectively address concerns that had been raised was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and relatives confirmed that senior managers did spot checks and observations. Comments included, "The last one was three weeks ago, they told a carer not to call my wife darling" and "(Staff name) is very nice, very caring. He came in, rushing about the other night, filling in all the forms, the care plans and reviews for last month." We were told that this was done to ensure all consent forms were signed.
- The inspector had raised concerns, during the inspection, regarding the lack of travel time in the rotas. The provider sent us rotas, after the inspection, showing travel time had been allocated on some rotas. However, we were not able to judge that this had been applied in a consistent manner across all visits and had been embedded.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff enjoyed their role and told us they had a good relationship with people they visited. However, we were told many experienced staff had left the service recently and had been replaced with some inexperienced staff. This had put pressure on existing staff to work longer hours.
- CQC and the local authority had requested that investigations took place in to the concerns received from people using the service and anonymous whistle blowers. The registered manager had undertaken investigations, but concerns had not been resolved and opportunities to help improve the service had been missed.
- When people or staff raised concerns about staff not supporting people well, management told us that action was always taken. However, some staff told us that some poor staff practices continued. This meant that action taken had not always been effective.
- Care plans contained person centred information and detailed how people's needs were to be met in line with their wishes and preferences. However, as detailed in the Safe and Effective sections of this report, the way the service was run did not always lead to good outcomes for everyone.
- One healthcare professional told us, "We do get concerns from families about their visits. It seems that if a package of care becomes difficult, they hand the package back to the local authority. It is not always helpful."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The Care Quality Commission (CQC) had received information of concern, stating that the management team did not respond effectively to concerns raised.
- People were asked about how any issues or concerns raised, were dealt with by the service. Comments were mixed with some people saying they had a good response from the office and others saying they had given up trying to get the response they needed.
- Staff told us, "I have fed back concerns to the office. Nothing changes" and "We keep telling them, but it does not help. People get really wound up about it."
- Relatives also reported raising issues with the service and not receiving a satisfactory response.
- The registered manager had responded in detail to concerns raised to CQC and the local authority. These responses had not been recorded in the complaints file at the service and there was no record of what action had been taken or how the concern was resolved. This meant people, relatives and staff often did not get resolution to their concerns.

The failure of the provider to respond effectively to people's poor experiences and concerns is a repeated breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.

Working in partnership with others

- A social care professional told us the registered manager attended local forums and meetings with a view to improving the service.
- The service worked in partnership with key organisations to support local care provision.
- The local commissioning service told us, "The service have recently taken on a number of new packages to assist us with pressures in the system. They always answer emails and respond in a timely manner."

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 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure staff always respected people's personal preferences, lifestyles and care choices. Regulation 10 (Dignity and Respect) (1)
Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure systems and processes were established and operated effectively to assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity. Regulation 17 (Good Governance) (1) (a)