Clece Care Services Limited

Clece Care Services Limited - Buckinghamshire

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 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 2, 3 and 4 October 2017. This was Clece Care Services Limited – Buckinghamshire's first inspection since it registered with us in June 2016.

The service provides domiciliary care to people in their own homes. At the time of the inspection they were providing personal care to 137 people.

The service had a registered manager. They had been registered with the Commission since February 2017. 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.

During 2017 the provider had experienced difficulties with the delivery of the service. We were told by the registered manager and the operations manager this had been due to high levels of staff sickness which resulted in a shortage of staff. This had resulted in a high volume of late or missed calls to people. Recognising the risk this placed people at the provider had worked with the local authority to subcontract some of the care to other organisations until such time as they had sufficient staff numbers to manage the care safely.

Our inspection took place at a time when changes were being made which was having a positive benefit for people. Staffing numbers had increased and there was acknowledgement from a small number of people that improvements were being made in some areas. However overall, people felt they had been let down by the provider. Repeatedly throughout the inspection we were told about the missed and late calls and the impact this had for people. The provider acknowledged the situation and was working hard to improve the service for people.

Although people were still receiving late or missed calls the number had reduced to less than 1%. People and staff felt the scheduling of calls was partly the cause, as staff were not allocated travelling time. The registered manager told us this was being addressed and they were ensuring staff got breaks throughout the day. Not all staff were aware of this. We have made a recommendation about improving the numbers of staff available to support people.

Medicine records were not filled in accurately. Information related to the prescribed medicine was not comprehensive, and unexplained gaps were found on a number of Medicine Administration Record (MAR) charts. Checks carried out by the supervisors did not identify the concerns we found.

Due to a lack of clear documentation we were uncertain as to whether anyone receiving a service lacked the mental capacity to make decisions for themselves, even though some records implied they were not able to. Even though staff had received training they did not understand the Mental Capacity Act 2005 (MCA) or how

this applied to the lives of people they cared for. We have made a recommendation about training for staff in this area.

Care plans and risk assessments were not robust in their content and this placed people at risk of receiving inappropriate or unsafe care. Care plans were not always person centred and there was minimal information about people's preferences and how they wished to be cared for. We have made a recommendation about how care plans could be improved to include this information.

Recruitment systems were in place to ensure the risk of employing unsuitable staff was minimised.

People spoke positively about their relationship with some staff. They enjoyed their company and looked forward to their visits. Other people found some staff did not appear to know what was required of them, or their attitude was not professional. Staff had attended training and were receiving regular supervisions. Spot checks were carried out on their performance and where needed additional training was offered. Three monthly reviews were carried out with people to revise their care and the staff performance. This took the form of face to face reviews and alternate telephone reviews.

People received support with their health needs, and where required support with food and drink.

Some people told us they did not always receive a positive response when they tried to communicate with the office staff regarding the timings of calls. Others found the staff supportive and responsive to their requests for help. They told us they felt carers listened to them and responded to their needs.

Although audits were carried out to identify areas the service needed to improve, they had not identified the areas we found during our inspection. This did not enable the registered manager to have a clear oversight of the service.

There was a mixed response from people and staff as to whether the service was well managed; this was influenced by people's experience of the service.

The provider had failed to comply with the legal requirement to notify us of safeguarding concerns that had been raised with the service. This was discussed with the registered manager who was unaware of this requirement. They assured us this would not happen again in the future.

We found a number of breaches 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 the 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

Some aspects of the service were not safe.

People were placed at risk of harm as carers were not always available to carry out care visits at the agreed time.

People's medicine records did not demonstrate that medicines were administered safely and consistently.

Care plans and risk assessments did not always accurately describe the risks associated with people's health needs. Care plans did not provide detailed information in relation to risks. This placed people at risk of receiving inappropriate care.

Is the service effective?

Requires Improvement

The service was not always effective

Records showed people had access to health care appointments when needed. This ensured people's health needs were maintained.

Staff were unable to demonstrate a clear understanding of the requirements of the Mental Capacity Act 2005. There was no documentation in relation to mental capacity and decision making. We were told no one lacked mental capacity.

Where people required support with eating and drinking this was provided by staff who had received training in the area of food and nutrition.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff demonstrated how they protected people's privacy and dignity. They were able to give examples of how they showed respect to people.

Some people experienced poor communication from office staff when care visits were going to be late. This was being addressed by the registered manager.

Some people had engaged well with staff, enjoyed their company and looked forward to their visits.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not focussed on people's preferences or how they wished care to be provided. Without this people had limited choice and control over the care provided.

People knew how to make a complaint, but did not always feel confident to do so. There was a mixed response from people about how well their complaint had been handled by the provider.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A lack of quality monitoring in some areas such as medicines records and care records meant improvements had not been identified or implemented.

Some people did not feel the service was well managed as they had experienced late or missed call visits. This placed them at risk of harm.

The provider had failed to notify CQC about safeguarding concerns that had occurred in the service. This is not in line with regulatory requirements.

Clece Care Services Limited - Buckinghamshire

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.

The inspection took place over three days on 2, 3 and 4 October 2017. It was an announced inspection which meant we gave the provider 48 hours' notice as we needed to ensure there would be staff available to assist with the inspection. The inspection was carried out by an 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. For example dementia care.

Prior to and after the inspection, we reviewed information we held about the service including notifications. Notifications are changes or events that occur at the service which the provider has a legal duty to inform us about.

We did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed this information during our inspection.

During the inspection we spoke with 11 staff members including the registered manager; the operations manager, the regional operations director; five care staff, and office staff. We spoke with 16 people who used the service and two relatives. We received feedback from the local authority contracts department, safeguarding department and care management team. We used this information to plan our inspection.

We reviewed documents associated with 12 people's care and medicine records for four people. We checked records associated with the employment of four staff. We read records related to complaints, staff

training and support and audits connected to the running of the service.

Requires Improvement

Is the service safe?

Our findings

Some people told us they felt safe with the care they received, comments included "Yes I feel safe with staff, there are some I haven't liked but I've never felt unsafe." "Yes I do, I don't think they would harm me, I'm 85 years old!"

People told us their care visits were sometimes late. 13 people out of the 16 we spoke with said they had recently experienced late visits, seven people told us they had experienced missed visits. People's comments included "I feel concerned that my [relatives] drugs are often late being given due to them not coming when they say they are." "A few weeks ago, I waited for 2 calls and they didn't come." "One weekend I was sat waiting for the Sunday staff to arrive I rang and asked where she was and they said she was running late, I was sat in my nightdress until 12.20." One person told us how the provider had asked them to self-care and care for their relative over the weekend as they did not have enough staff. They said "My relative has dementia and diabetes; they get hungry and I struggle to get to the microwave." They also described how when new staff were added to the rota or staff were late attending to them the relative became "really agitated" and this meant they were "difficult to deal with."

Staff told us they felt the problem partly lay in planning the schedules for visits. Routes staff had to take to get to people's homes had not been taken into consideration. Their comments included "We don't get travel time, so the rota shows where we are supposed to be but doesn't allow travel time to get there, so we are always late." "I am a walker (does not drive). I pass a client's house five minutes away from my home and another 20 minute walk from my home, yet I am scheduled to work in Marlow. It takes me 45 minutes to walk to my co-workers house to get a lift, as there is no public transport at that time in the morning." "They [provider] are slap dash. I am always complaining they [provider] take short cuts.....How can you be turning up at 10 and 11 o'clock at night…They want you to drive half an hour for a fifteen minute call." Quality assurance records had recognised that office staff were not always contacting people if their calls were going to be late. However, although the action was to improve this area, there was no up to date information in the record to show this had been measured and improvements had been made.

We discussed our findings with the registered manager and the operations manager. They told us they had experienced problems in the last few months, with staff sickness and low staffing levels. They had alerted the local authority to their concerns and had taken action to sub contract the care packages to organisations who could temporarily meet the demand. Through the local authority auditing process they showed us figures that evidenced their late calls (i.e. calls that had commenced two hours later than had been planned) had reduced from 85 in May/June 2017 to 52 in July /August 2017. We were shown visit records that confirmed action had been taken to improve the timing of calls to people. Due to the increased staffing levels it was possible that visits would be nearer to the agreed time. Recruitment of staff was on-going, and as the staff team increased the availability of staff to attend calls would be improved. The provider had started to allow 5 minute travelling time between calls, and made sure staff got breaks, however feedback from some people was still negative in this regard. Not all staff were aware of the added travelling time or the breaks. Some people felt that improvements had started to happen and staff were now more consistent.

We recommend the provider ensures there are sufficient numbers of staff in place to meet the needs of people and keep them safe.

Where people were prompted or supported through the administration of medicines by trained staff. We found the Medication Administration Records (MAR) charts we looked at were not fit for purpose and not were not in line with the National Institute for Health and Care Excellence (NICE) guidance on managing medicines for adults in community settings. For example, on one person's chart two prescribed creams had been crossed out and the name of two other creams were hand written on the chart. There were no signatures to identify who had made the amendment, and to demonstrate the information had been double checked with the prescription and was accurate. For some creams there were no explanations given as to where the cream or lotion needed to be applied. Where the area that required the cream had been recorded it was not always clear, for example "For the rear". Some did not have specified times for application and there were not always descriptions of routes for administration, for example, oral.

When staff supported a person with their medicines they signed the MAR chart to evidence they have completed the task. There were numerous gaps in the MAR charts where staff had not administered the medicine. For example, one person's MAR chart for the administration of two creams had 56 gaps over a one month period. Records gave five explanations of why they had not been administered. We discussed this with the registered manager and the operations manager. They told us they had a system of auditing the MAR charts. The charts were sent to the provider and they were checked monthly. We were told that sometimes the staff recorded the reason for not administering medicines in the communication log rather than on the MAR charts. Following the inspection a copy of the audit for the MAR chart that showed 56 gaps was sent to us. The provider had identified there were 15 explanations given on the MAR chart and in the communication log for gaps on the chart. This left 41 unexplained gaps on the MAR chart. Where explanations were recorded as to why the medicine had not been administered these were not always clear.

We were told by the registered manager that staff who had been identified as not signing the MAR charts correctly had received further training in medicine administration. Following the inspection the registered manager sent us copies of the training certificates and information showing seven out of the 16 staff had received retraining or competency assessments regarding medicine administration. This did not confirm there were robust systems in place to address medicine recording and administration errors. This did not demonstrate medicines were recorded or administered in a safe way, placing people at risk of harm.

Some risks associated with the provision of care had been identified, for example environmental risk assessments had been completed and were documented in care plans. However, we found a number of areas of concern where risks had not been clearly identified. Records did not demonstrate how to minimise risks. For example, people's medical histories and conditions had been recorded; however we found there were no explanations of how the person's medical conditions may impact on their day to day life. For example macular degeneration and atrial fibrillation. Macular degeneration is an eye condition that would get worse over time. Atrial fibrillation is a heart condition which can cause dizziness, shortness of breath and tiredness. The impact of these and other illnesses had not been reflected in the care plans.

We also found contradictory information in care plans regarding risks, for example one person was required to have a "Fork mash-able diet," however the care schedule referred to supplying them with snacks of biscuits. Care plans referred to the use of hoists and slings, but gave no direction to staff on how to carry out the procedure, which sling was to be used and how the sling was to be attached to the hoist. For example, one person's plan stated "Place my sling on me and hoist me up." We read one complaint made to the

provider stating that staff were unclear of what loop to use on the sling, and because of this the person was at risk of falling out of the sling and had experienced pain. A review of the care plan in January 2017 stated "Correct loop instructions for client would be advantageous for providing safe and comfortable transfers." We found no evidence this had been implemented." One staff member told us care plans were not always up to date, they said "If we don't have a proper understanding of our job, we can't do it to the standard we should." This placed people at risk of receiving inappropriate or unsafe care.

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

Risk assessments had been completed in the areas of moving and handling, environmental risk, medication risks, and mental health risk assessments. Where appropriate assessments had been completed regarding people's risk of dehydration. This protected people and staff from the risk of harm.

Staff had received training in how to protect people from abuse. They were aware of the indicators of abuse and what action to take if they had concerns. We spoke with the registered manager about their knowledge of how to safeguard people. They understood how to manage allegations of abuse and what action they were required to take. However, the registered manager had failed to notify us of a number of safeguarding concerns that had taken place in the service prior to the inspection. This is a legal requirement to ensure we are aware of any concerns in the service.

The provider had systems in place to recruit staff. This included obtaining an application form, following up references and interviewing staff. The records showed each successful candidate was checked through the disclosure and barring service. This is a service which specifies if employees have any previous history that is known to place them at risk to working with people. Files included evidence of identity, and health screening questionnaires to ensure employees were fit to work. This minimised the risk of the unsuitable staff working with people.

Requires Improvement

Is the service effective?

Our findings

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. Domiciliary care services must apply to the Court of Protection for legal authorisation to deprive a person of their liberty.

We were told by the registered manager they did not provide care to anyone who lacked the mental capacity to make their own decisions. However for two people their care plan stated they were "Unable to hold a rational conversation" and were "Disorientated to time and place." For a third person we read in their care plan they were fed via a Percutaneous Endoscopic Gastrostomy (PEG) rather than orally. The staff were instructed to flush the peg feed tube as part of the care provided. The care plan stated this was used for times when the person refused to eat. We saw no documentation to verify whether the person had consented to the PEG feed or whether they had the mental capacity to give consent. We could not be certain the person did or did not have the mental capacity to consent and there was no evidence the best interest process had been followed. A consent form in the care plan had been signed by the person's relative, but the care plan stated there was no authorisation by the court of protection for another person to make decisions on their behalf. Without clear documentation we were not able to tell if the use of the PEG was a deprivation of the person's liberty or not. Staff received MCA training. However they were not able to tell us how this applied to people's lives.

We spoke with the registered manager who demonstrated a basic understanding of the Act. Some people receiving care from the provider had the mental capacity to make their own decisions. We read they had given consent in their care plans to receive care.

We recommend that the service seeks advice from a reputable source on training for staff, based on current best practice, in relation to the Mental Capacity Act 2005.

There was a mixed response from people's relatives when asked if they felt the staff were suitably trained and experienced to provide their care. Some people told us they felt staff were competent; their comments included "I nearly always get the same carer Monday to Friday and she is amazing, just wonderful. Weekends are a very different story." "The male carers are great they know what I want doing and do a good job." "I'm happy with most of the staff and how they are trained this has never been an issue." Others were less positive, their comments included "Some are alright some are quite good but others are not." "When they are good they are usually really good but some of them just stand and look at you and you have to spoon feed them as to what you want, its hard work." "Most of them are quite nice and some of them you just wish they weren't there. They don't do what you want them to do; they come up with excuses and it makes me feel uncomfortable."

Records showed all staff received training deemed to be mandatory by the provider. For example, fire safety and safeguarding adults amongst others. Specialist training was also provided to staff who worked with people who had specific health needs for example, PEG management. This enabled staff to meet the needs of the people they were supporting. The provider had employed an internal trainer.

Spot checks and observations were carried out on staff to assess the quality and safety of the care being provided. Records showed where concerns were identified additional or refresher training was provided or discussions through supervision aimed to improve the practice of staff. Contact telephone calls were made with people receiving services and home visits to discuss the quality of the care being provided and to ensure any required changes to people's care were discussed and documented.

New staff received an induction which included training and shadowing more experienced staff until they were deemed to be competent to work independently. Supervision records demonstrated how staff were regularly supported to perform well and included clear guidance from senior staff on how their work could be improved. Supervision took the form of a monthly rotation of observations, telephone calls and face to face meetings, staff told us they found these sessions useful.

Where people required support with eating and drinking this was provided by staff who had received training in the area of food and nutrition. People told us they were satisfied with the food and drinks that were prepared for them. One person told us "They make everything I like or want like vegetable soup and yes, I have enough to eat. I have put on weight since being with them. Before I was so skinny and I had no appetite." Staff understood the importance of preparing food in a way that was both nutritious and appealing. Where people had special dietary needs the staff were aware of these, for example a soft diet. One person told us "I can manage to make snacks but they always check I've eaten and encourage me as I have had a few issues with my eating and they just prompt me to eat." Another said "If it wasn't for staff there would be days when we wouldn't have even a cup of tea, they just get on with whatever we need without being asked. They take us to the café and trips out to get us motivated."

People had access to health care professionals and were supported to maintain good health. Reports showed people had received support from specialist healthcare workers such as mental health professionals and GP services. People told us staff supported them to maintain good health. One person said "The staff have called the doctor on a few occasions as they felt I was under the weather they are great at just watching out for me."

Requires Improvement

Is the service caring?

Our findings

People had mixed experiences of being cared for by staff. Comments included "Some [staff] are more caring than others. Last week, or the week before, they [staff] were nattering and jabbering with each other talking. The ones that talk to me make me feel better." "They are kind and caring. One of them sometimes slumps down her head and says 'I'm so tired'". "They are nice and kind and they talk to me." "They motivate us both and work to our strengths they are willing to do anything you ask".

We received a mixed response from people when we asked them about how the service communicated with them. Some people felt communication in relation to late calls was not effective. Comments included "Occasionally the office will let you know but most of the time you have to ring them to ask where staff are and check they are coming." "When things are really bad they don't answer the phone, you get an answer machine and as staff are often late in the evening they tend not to answer the phone." Others told us they had a positive experience when speaking to office staff. "I've rung a few times and had a positive response." "Yes they seem to sort the problem out then ring you back as soon as possible." Following feedback from people using the service the registered manager had implemented customer service training for all the office staff to improve the responses people received from staff.

People told us the staff showed an interest in them as people and were not just task focused. They described to us the impact the staff had on them. They told us "We get on well I know all about her family and she mine I feel she is like my family". "The two guys I have now, we have a good banter and I enjoy and look forward to them coming." "We both have conditions that mean there are days when we can't function. The staff adapt to this so easily and support us accordingly without any judgment or questions." Another person said "If time is running out and they haven't finished they will stay on until I'm done. I know they have to go elsewhere and they are busy but they always make me feel good about my visits."

Staff knew how to protect people's privacy and dignity. They gave us examples of ensuring the environment was private when carrying out personal care. This was confirmed by people who told us "She [staff] covers me when we are showering and makes sure I have some dignity rather than sat with no clothes on." "Yes they're very respectful of my dignity and privacy."

Staff encouraged people to be as independent as possible when carrying out personal care. They were aware of people's limitations and knew how to encourage them. One staff member told us "I like to encourage people to do what they can. I don't take over, it is their right and I help them where it is difficult for them to manage." Another staff member told us "I encourage them to be independent by allowing people to be in control, as long as they are safe and are not at risk of harm, I support them when necessary."

People told us they felt listened to by staff, and that their opinions were important. One person told us "I feel my carers really listen to me and I feel safe in their care." People were offered a choice of male or female carers; however we were told by the registered manager that sometime this would not always be possible to deliver depending on the availability of staff. People told us "I'd prefer male carers and at the moment I'm getting two blokes coming which has taken some time to get organised." "I would prefer a female but I have

two very nice men". "I have a female and my husband has a male." We read feedback from one family who stated they did not want Asian females caring for their Asian relative. From their perspective this was due to a cultural issue. It was apparent that this had not been discussed during the assessment process. The registered manager had taken steps to rectify this situation, and learn from it following the feedback.

Requires Improvement

Is the service responsive?

Our findings

People told us and documents verified that each person had received an assessment of their needs prior to care being provided. Comments included "Yes the first time she came to see me it took two hours" "Yes we had a visit and they asked lots of questions which seemed quite thorough". From this information a care plan and risk assessments had been completed. People told us a copy of this was kept in their homes.

Care plans were task focussed and not wholly person centred. For example, there were details relating to people's physical welfare and schedules of care but little information related to people's health conditions. It was important for staff to understand the implications for people of their medical histories, to ensure they maintained good health. In addition, staff needed to be aware of symptoms related to people's medical conditions that could be having an adverse effect on their health and wellbeing. This would enable staff to ensure care was appropriate and safe.

There was limited information about the person's like, dislikes and how they wished to be cared for. The only information we found in this regard was related to some people's food preferences for example, one person's care plan referred to breakfast as "Porridge made with milk, coffee two sugars." Some people had information included in their care plan which related to their personal history, this was documented under the heading of "10 interesting things about me." There was no further information about their likes, hobbies, interests or how they wished scheduled care tasks to be carried out.

Some tasks were not clearly described, for example one person's care plan stated "Assist with bath" but did not describe how this should be carried out. Another person had a catheter in place, there was no information stating if the person required support with this. Other staff were expected to support a person with their PEG. The directions in the care plan stated "Flush water via PEG every evening" There was no information for staff on how to do this. Another person's care plan stated "I will wear a slipper on my left foot and a sock on my right foot." Again there was no information to explain why this was the case.

We recommend the service seek advice and guidance from a reputable source, about recording people's views and preferences related to their care and reflecting this information in care plans.

Staff told us they knew how to deal with complaints. The provider had a complaints policy and procedure; and complaints log. We reviewed the complaints recorded in the log, of which there were 24 since January 2017. We noticed these all related to the lateness or lack of care visits. The number of complaints increased from two in July to eight in August. This was at the time the service was experiencing problems with staffing. At the time of our inspection there had been one complaint in September. Five people told us even when they were unhappy they did not complain. Their reasons were "I don't like to be any trouble." "I don't like to rock the boat and complain" "I don't like to complain I don't like to make a fuss".

Other people who felt confident to raise concerns and complaints told us they had no problem doing so. There was a mixed response in relation to how their complaints had been handled and the response they had received. "When things are really bad they don't answer the phone, you get an answer machine and as

staff are often late in the evening they tend not to answer the phone." "Carers good, office staff not good when they can't answer your problems they don't answer the phone as they know there is a problem. My wife gets frustrated they are really hap hazard with their support" "I have no problems ringing up and chatting with the office staff if I'm not happy I've never complained as in really complained but if I need things changing I just ring up and they are always happy to help you." "When I've rung the office to ask where staff are. I always get treated respectfully and they get back to you quite promptly."

Feedback from the quality audit questionnaire sent out to people recorded people were sometimes unsure how to make a complaint. The registered manager had recorded that each person receiving care had been reminded of where their complaints procedure was located in their service user guide. Each person had signed to acknowledge receipt of the complaints procedure.

To assist with identifying concerns each person received a phone call or visit every three months from supervisors. They would ask for feedback on the care being provided. From the records we saw the majority of concerns raised were regarding staff lateness and missed calls. The provider was working hard to rectify this situation. Other opportunities people had to feedback to the provider was through the annual questionnaire. This covered areas such as staff performance and visits as well as complaints and care plans. The registered manager had used this as a template for improving the service to people.

Requires Improvement

Is the service well-led?

Our findings

Audits had been completed to identify areas of the service that required improvements. These included medicine recordings and administration, reviews of care plans and of care. However, these had not identified some of the things we found. The provider kept a record of when people's medicine records were audited. This showed that 41people's records out of the 90 people receiving support with medicines had been checked this year. Of the 41 people's charts that had been checked only five had been checked on more than one occasion this year. The delay in checking the records meant medicine errors could go unnoticed and this placed people at risk of harm.

The action plan from the annual questionnaire sent to people identified areas that needed improvements. However, not all actions had a completion date. For example, 19% of respondents stated they had a poor experience in relation to being informed if care visits were going to be late. The improvement plan stated the action for coordinators was "Phone calls to be made to clients if there is a change to their care call." This was recorded as "On-going". Whilst the area of improvement had been noted and an action plan had been put in place, there were no measures recorded to check if this had improved or not. The introduction of regular detailed audits to check on documentation and the quality of care being provided would improve the management oversight of the service. It would also assist with driving forward necessary enhancements.

Records were not always accurate or person centred. Discrepancies in information had not been identified during care plan audits. This led to gaps in information and conflicting information regarding the care to be provided. The records we viewed during our inspection were not always accurate or up to date.

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

We asked people if they felt the service was well managed. Their comments reflected their concerns about the lack of consistent visit times. To them this reflected a service that was not well managed. Comments included "This company don't understand the way to organise staff, they send them up and down the place with no consideration to travel time, it's really bad for staff and they won't get the best of people by treating them like this." "The office let the staff down a lot, they add names to their rota and give them too many visits. This company don't know the area well and will send them all over, backwards and forwards it's really hard for staff and it seems so much worse at weekends" One person felt they had received a positive experience from the service they told us "I can't fault anything about this company at all it seems well led professional and organized."

During the initial assessment, people or their relatives were able to discuss with the provider their preferred times of care visits. People's expectations were managed as not everyone could have a care visit at the same time. The provider explained to people that there was a two hour window for the timing of each visit. This meant the care staff could attend their care call up to an hour before or an hour after the agreed time. The response we received from people was this was not acceptable. People complained the office staff did not always inform them in advance when changes to their care visits occurred. We discussed this with the

registered manager and the regional manager. They showed us evidence of how they were working towards improving the timings of calls through time schedules being nearer to the time of the planned calls. We could see some improvements had been made. The provider was working towards restoring people's trust in the service.

People commented that most carer's provided a positive service "Oh yes, she's [carer] is absolutely brilliant. She looked after me better than the doctor when I fell." "They are supposed to come at 9.30am and they come within an hour or two of that. This is fine for me because I like to have a lay-in. They ring a bell which plays a special tune so I know it is them… they are very obliging." "They are amazing, they have worked so well with my daughter most of them are similar age to my daughter and this has been really good as she has a lot in common with them rather than older carers. They go out and do loads of good things together. I can't emphasize enough how delighted I am with this company they are a real god send for me. As a parent you just want the best support for you daughter. I can believe how lucky we have been finding them."

There was a mixed response from staff regarding whether the service was well managed. One staff member told us "Whenever I have a problem they [manager] are very sweet and considerate, but it takes a long time to handle an issue." "Yes because I have worked for other companies, and they didn't listen. If an emergency comes up they [office staff] cover the call, they and the manager are very helpful." "There is always room for improvement. The staff could improve on communication." Staff generally felt there was a lack of coordination with the location of their visits, and that rotas could change at very short notice. However, they were appreciative of the recent developments which included comments such as "It used to be that the calls were often late. I came back from holiday two weeks ago and found out we now get breaks and travel time…It is work in progress." "I've seen a lot of improvements recently, before there were a lot of problems. Now lots of girls are getting their own round in one area." "There have been changes recently, the rota is more settled. I know where I am going in advance. I don't have travel time, but we are hoping this will improve as this is one of the main concerns we have." We were told by the registered manager that breaks for staff and travel time had been introduced recently, however, some staff told us this was not available to them, whilst others verified it was happening. It appears there is some confusion with regards to this situation.

Prior to the inspection we checked which notifications we had received from the service. We noted we had not received any safeguarding concerns from the provider. We checked with the local authority safeguarding team, who were able to send us information related to a number of safeguarding concerns within the service. This information was confusing, as when we checked with the registered manager during the inspection, they reported to us that some of the safeguarding concerns were associated to the services they had subcontracted to. It remained apparent that for the safeguarding cases related to Clece Care Services Limited – Buckinghamshire; these had not been reported to us. We spoke with the registered manager about this. They told us they were unaware of the need to do so, and would ensure in the future this would be improved upon.

This was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

Most of the staff we spoke with told us they felt supported by the management of the service. The regional operations manager told us they had 22 lease vehicles that were available for staff to let. This was to enable staff to be employed without the added expenditure of buying a vehicle. They also held a carer recognition award each month. This was to acknowledge the achievements of individual staff members who were awarded a £20 voucher. There was also a raffle which staff could enter into if they had been employed between the 1 August 2017 and January 2018 prizes included a spa day, luxury hampers and a £100 voucher. This was to encourage staff retention and acknowledge the commitment shown by staff to the company.

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 18 Registration Regulations 2009 Notifications of other incidents The registered person failed to notify the Commission without delay of any abuse or allegation of abuse in relation to a service user. 18 (1) (2) (e)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess the risks to the health and safety of service users of receiving the care or treatment. They failed to do all that is reasonably practicable to mitigate any such risks. The provider failed to ensure the proper and safe management of medicines. 12 (1) (2) (a) (b) (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). The provider failed to evaluate and improve their practice in respect of the monitoring they had completed to drive forward improvements. 17 (1) (2) (a) (b) (c) (e) (f)