Domriss Care Limited

Domriss Care

Inspection report

Suites 2 & 3 Unit 1
Stratton Park
Biggleswade
Bedfordshire
SG18 8QS

Tel: 01767312500
Website: www.sevacare.org.uk

Date of inspection visit:
17 May 2016
18 May 2016
27 May 2016

Date of publication:
18 July 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on the 17, 18 and 27 May 2016 and was announced. The provider was given 48 hours' notice of our inspection so we could be sure they were in for our inspection.

Domriss Care is a domiciliary care agency based in Biggleswade providing personal care to people in their own homes. At the time of our inspection there were 60 people using the service. Although the company responsible for operating the service remained unchanged the service was acquired by the Sevacare brand in January 2016 and the former directors and registered manager had left the service as part of this acquisition.

The service did not have a registered manager. There was a branch manager in post who intended to register but left the role on the second day of our inspection. A new branch manager was appointed immediately and planned to make an application to become the registered manager of the service. 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.

Our inspection identified serious issues regarding the management and leadership of the service and the quality of their care delivery. Whilst there was some evidence of positive progress towards developing robust systems to support the delivery of care and support, there was a lack of consistent managerial oversight. The poor feedback from people and staff regarding the quality of the care and support showed that the changes were not being implemented or embedded within acceptable timescales. As a result we took urgent enforcement action on the 27 May 2016 to restrict new care packages being undertaken by the service.

Staff were caring and compassionate and respected people's privacy and dignity when delivering care. People told us that they generally received good care from their regular care staff, but late or 'clipped' (cut short) calls were reported. The electronic records that accounted for people's visit times demonstrated that some people did not always receive care for the full duration of their visit. Because these records were poorly maintained, with a large amount of inaccurate information being manually input to the system used by the service, it was impossible to ascertain an accurate picture of exactly when staff arrived or the length of time they stayed for. Staff reported feeling under pressure and rushed since there were occasions where travel time was not incorporated into their daily rotas.

People had care plans in place which were reflective of their basic needs but lacked personalisation or detail to enable staff to offer person-centred support. Risk assessments were generic in nature and insufficient to help staff to keep people safe. People's medical conditions were listed in their initial assessments but not always included in plans. People told us there was a lack of flexibility from staff. Staff had been told not to offer any support outside of the care plan which meant that simple tasks that needed to be completed were

left unattended to. People who needed support with eating did not always have their dietary conditions detailed in their plans. People received their medicines and there were systems in place for safely managing and auditing these. However there was not always sufficient information in care plans to support staff to understand people's preferred method of administration.

Staff were recruited safely to work in the service and checks were carried out to ensure that staff were suitable prior to commencing their employment. Staff received a full induction into the service when they first joined. All staff had received basic training in areas the provider considered essential although the majority of staff had not had their training refreshed. The provider had committed to training staff before the end of July but courses had not yet been booked at the time of our inspection. Staff did not receive training in the Mental Capacity Act and care plans did not contain information around consent or capacity. Staff had recently received supervision although these had been infrequent and no staff had received a formal appraisal of their performance. Only one team meeting had taken place since the new directors had begun in the service in February.

There were quality monitoring systems in place which were effective in identifying areas for improvement within the service. However improvements were not being made within acceptable timescales due to a lack of managerial oversight in the service. People, their relatives and the staff were not clear as to who was managing the service or who they would complain to.

The service was able to demonstrate positive progress towards improving quality during our last visit and was taking proactive measures to address the issues raised.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People did not always receive their calls on time and rotas did not always include adequate time for staff to travel between calls.

Risk assessments were generic and not always reflective of people's individual needs.

Staff were recruited safely to work in the service.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had received training but were not regularly refreshed.

Staff were not trained to understand the Mental Capacity Act (2008).

Staff did not always receive regular supervision or appraisal of their performance.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were not always flexible in their approach to supporting people as they were told not to offer support outside of the care plan.

Staff were caring and respectful towards people and treated with them with dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not person-centred and contained minimal detail.

People and staff were not always sure who to complain to or confident that their complaint would be dealt with appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

People were not sure who the manager of the service was and the management was not visible or supportive of their staff team.

Quality monitoring systems were in place but improvements were not being made or embedded within acceptable timescales.

Data held by the service in relation to people's call times was not always accurate.

Domriss Care

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place over three days on the 17, 18 and 27 May 2016 and was announced. The provider was given 48 hours' notice of our inspection as they provided a domiciliary care service and we needed to ensure somebody would be available in the office to meet us. The inspection was carried out by four inspectors, an inspection manager and an expert by experience who made phone calls to people using the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed the information available to us about the service, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with 12 people who used the service and seven of their relatives to gain their feedback. We spoke with seven members of care staff, the care co-ordinator, area manager, registered manager and administrator.

We reviewed care plans, risk assessments and daily records for 10 people who used the service. We looked at training and recruitment information for 10 members of the staff team. We reviewed information about how the service was monitored and audited and reviewed minutes from team meetings. We looked at the records of call times and how these were audited.

Inadequate

Is the service safe?

Our findings

People we spoke to consistently expressed dissatisfaction and concern at receiving late or missed calls from the service. One person said, "It's the late calls I don't like, I used to have calls at 8am and 4:30. My usual care staff goes away and everything goes up the wall. They're sometimes two hours late and I have to call the office to ask where they are." Another person told us, "I would like a rota so I know when somebody's going to turn up. I don't know who is coming and I have to have my calls on certain days and certain times. How many times have I called them and told them this? It has an impact on my day, I need to go out and there's no ifs and buts about the times I need. It upsets my whole day if I don't." A third person remarked "I have problems with their reliability. They were supposed to come on two days a week for an hour but I've had about three or four cancelled calls now."

The staff we spoke told us that the rotas they worked to did not allow them to spend enough time with people or arrive to calls on time consistently. One member of staff said, "They're putting calls on top of calls, the rotas are a mess, they're horrendous. I've told them so many times." Another member of staff told us, "We go in and pick our rotas up every week but travel times aren't included. I had to drive several miles between calls that you don't get paid for and there's no time allowed. It impacts on the customers because they don't know what time we're going to show up. It's really not on." Five members of staff we spoke with expressed that the rotas were not always well managed and that their availability was not taken into account. Staff told us they were consistently asked to travel for 15-20 minutes between calls with insufficient time for travel included on their rota. We reviewed the rotas for the service and found that sufficient travel time was not always being allocated for staff. For example five minute travel times were being allocated between two locations for journeys which were approximately seven miles apart and took at least 14 minutes. This meant that calls were being 'clipped' or cut short or that staff were sometimes late.

One relative described the impact upon their family member of having late calls. They said, "[Relative] has an hour call in the morning but they keep changing the times. She needs a 7:30 call to get up and go out. The staff don't have travel times in their rota so we don't know when they'll be turning up. That has an impact on [their] routine and their whole day." Another relative told us their loved one had been left in bed for over an hour and a half with no indication of when staff were due to arrive. They said, "We've been let down a few times, once I had to get [relative] up myself because nobody arrived and we weren't told. [Relative] was just left in bed. They're unreliable. Sometimes the carers call the office to let them know they're running late but the office don't call us. There's a lack of communication at times. I don't bother bringing this up anymore because it seems to just fall on deaf ears."

We reviewed the work records for 10 people using the service which showed us the planned times for people's calls and the times that staff had logged in. We found that the consistency of these varied for each person but that the data was not always accurate. Staff were required to log in to the system to indicate their times of arrival and departure but the data was frequently inputted manually and did not always represent an accurate picture of the times involved. For example there were occasions when two staff attended a call together and were supposed to spend half an hour with the person. One had logged a 15 minute visit but the other had not logged in and their visit time had instead been manually recorded as half

an hour, which was not accurate. Often, when a member of staff had failed to log in, the call was recorded as exactly what the planned times should have been. This meant the service was not cross-referencing daily notes or speaking to staff to get an accurate accounting of arrivals or time spent on visits. We found that for the period between the 8 March and the 8 May one person had their visits cut short by at least 10 minutes on 69 separate occasions. On 68 occasions the times had been input manually so it was impossible to know how long these visits had lasted. This resulted in the person failing to receive at least 73 hours of care over the period. There were consistent patterns of failure in this regard, with long visits and weekend calls going unrecorded at a disproportionately high level compared to routine weekly calls. On one occasion calls had been manually input when on-call logs showed that the person had not received care over the period in question. We were told that, in some cases, the manual inputting of data was due to people not always allowing staff to use their phones to log in and out. However this was not reflected in people's care plans and there were no alternative methods put in place to mitigate this and ensure the accuracy of the data.

When we revisited the offices on the 27 May the provider told us they were putting extra monitoring systems into place to ensure that staff were keeping to the correct times and using the electronic system correctly. Because there was no policy in place for missed calls, it was not always clear what constituted a 'missed' call although it was agreed that any delay over 20 minutes would be termed as 'missed'. We were sent records which showed that no calls had been missed in the four months prior to our inspection, but the large amount of manually input data meant that we could not be certain of the accuracy of these records. For example we saw in on-call logs that during one weekend a person had been admitted to hospital and therefore had not received support from the agency for two days. However data manually input into the electronic record suggested that they had received visits from staff. The lack of a clear policy or adequate monitoring systems in place meant that there was an on-going risk of people not receiving calls on time or staff staying for their full allocation.

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

There was a robust policy in place which detailed the process for recording and reporting incidents and accidents. While we were initially told that no incidents had taken place, we did see that there had been incidents noted in care plans which were reportable and were later supplied with a record of incidents through on-call logs. This meant that while the information was recorded, the service were not always able to evidence the subsequent learning or improvements that needed to be made as a result. The manager and staff we spoke with were clear on what constituted an incident or accident and said they would feel comfortable completing the paperwork and reporting these to the relevant authorities as required.

A risk assessment was completed with each person to determine the level of risk across different areas of their care. Whilst these were effective in identifying the level of risk, they did not always contain enough information for staff to know how to manage or mitigate it. The risk management plan was virtually identical for each person and the lack of personalisation meant that the actions identified to manage risk had not been considered on an individual basis. For example we saw that one person was listed as being 'physically or verbally aggressive' but no information was provided on how this might impact upon their care. This meant that staff who supported the person might not work to a consistent approach when managing behaviour which might have impacted negatively on others. Risk assessments had been completed for the risk of falls but there was no management plan in place to identify ways in which staff could reduce this risk. One person had been assessed as being at 'medium' risk of falling but there were no specific control measures or indication of how or when this might occur. We saw in another care plan that there were records of an incident that had occurred with one person in the previous year which might have presented a risk to staff working with them. However this was not reflected in their care plan and there were no

management plans in place to support staff when working with this person. We were told by the manager that the information could not be included in the plan because it would upset the person or their family, but we saw no evidence of how else this was being managed sensitively or how staff were made aware of this risk.

People's care plans included an assessment to determine the level of support they required with their medicines. This included a list of the medicines they took including any creams or lotions that needed to be applied topically. However the information provided was insufficient and did not include detail on how the medicine was to be administered, how the person liked to be given their medicines and the potential risks or side effects of these. Staff had received training to administer medicines but their certificates were often out of date. When we revisited the service we were provided with a list of dates booked for staff to refresh their training in medicines administration.

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

Prior to the inspection we noted that no safeguarding notifications had been made to the Care Quality Commission. In a service of this size this is identified as a potential risk because a lack of notifications may indicate that safeguarding concerns are not being reported. During the inspection we found that there had been a safeguarding investigation during 2015.This had been resolved, however no notification had been made to us by the previous management team. We spoke to the manager about this who confirmed that she understood what needed to be notified to the Care Quality Commission in future. There was a robust safeguarding policy in place which detailed the names of agencies that staff and people could contact if necessary. Staff demonstrated an understanding of their responsibilities to report concerns if they believed people to be at risk of avoidable harm.

Staff were recruited safely to work in the service. In the staff files we looked at we found that the service had sought references from previous employers and that all new starters were subject to a DBS (Disclosure and Barring Service) check. DBS is a way of employers making safer recruitment decisions and checking whether staff have any prior convictions on file.

Requires Improvement

Is the service effective?

Our findings

People we spoke with gave us mixed reactions when we asked whether they felt staff were effective. One person told us, "The ones that I know are fine, lovely girls. It's the ones they send you when they're not available that are the problem. I have to talk them through everything." Another person told us, "I don't want them anymore. They aren't trained to do anything properly. They can't make a sandwich, can't make a bed, I wouldn't have them any more unless they can take a bit more time and actually do what I ask." A relative told us, "It's a real mix in terms in quality. Luckily we've kept the same carers for a long time and they know [person] very well."

Staff had received training when they first joined the provider but we found that most of their training had not been refreshed, and that there was no evidence of how this was being addressed. Staff who had recently joined the service told us they received a three day induction which included training the provider considered essential. This included safeguarding, manual handling and medicines which were completed as part of a classroom-based induction. However, staff who had been with the service for a longer time had not received refresher or updated training and told us that the training they had received was poor and out of date. One member of staff said, "The only proper training I've had was manual handling training. The rest was e-learning and it wasn't worth it, I've not had anything since and I don't know when I will. It's worrying because everything I've done is out of date now." Another member of staff said, "All my training is out of date. I hadn't worked in care before I started here so I needed proper training but instead you get this multiple choice internet test."

The manager told us that it had been challenging refreshing staff training due to staff shortages and the need to fulfil people's visits. However we found that there had been no progress in booking staff on for refresher training and that staff were unclear as to when they would be next trained. We were shown a training matrix which showed that every member of staff was due to be trained before the 31 July 2016 but it was not clear how or when exactly this training would be provided. Having significant numbers of staff working with out of date or ineffective training meant that people may not have received an adequate standard of care and support. While most people were positive about the staff who visited them regularly, others expressed concern when newer staff were asked to work with them. There was no specialised training available to enable staff to better understand people's conditions or how to manage them safely. When we revisited the service we were given further assurances that all of the provider's mandatory training would be completed before the end of July and saw evidence that staff were being booked onto the provider's courses. During our visit on 27 May 2016 the Director of care for the provider acknowledged that improvements were needed and courses were being planned to meet the July deadline. They assured us that it was the company policy not to provide staff with work if their training had not been completed by the end of July 2016.

Supervisions had recently been completed with all staff and staff were positive about the quality of supervision they had received from the care co-ordinator, who later took over the management of the service. One member of staff said, "I had supervision with [manager], she's really lovely and it was really useful." We found that supervisions had been infrequent and that it had taken some time for staff to receive

their first supervision since the service had been taken over. Prior to that staff had only received one supervision over the course of the previous year. There were no appraisals in place and staff told us they were not aware of when they would receive a formal review of their performance. We were told on the final day of our inspection that these would be booked as soon as possible.

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

Staff had not received any training to understand the Mental Capacity Act 2005. 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. The member of staff responsible for completing all of the care plans did not have an understanding of what the MCA was or how it would impact upon the delivery of people's care. This meant that staff did not know how people consented to receiving care or were able to understand their capacity to make important decisions. While the staff we spoke with were able to describe the principles behind consent and tell us how they put this into practice, the lack of information in care plans meant that these approaches were not necessarily consistent.

People who required support with eating and preparing meals gave mixed responses when we asked them about the effectiveness this. One person told us, "They'll help me to make lunch and dinner; the girls are quite good at knowing what I like." However a relative expressed surprise that staff were only permitted to heat food using a microwave, saying, "We're told they can't make any fresh food and that everything has be heated up." One person told us that carers had been instructed not to make them food because it was not in their care plan, stating "They refuse to help me to make food." Care plans included whether people required support with eating and drinking but did not always contain enough information to inform staff of how to do this. One person was diagnosed with diabetes but had no special dietary requirements listed. People's likes and dislikes were not included and staff had to ask people what they liked if they were to prepare food for them. This meant that people who were not able to express this might not always have been given food they enjoyed or was appropriate for them.

Requires Improvement

Is the service caring?

Our findings

People and their relatives mostly told us that the regular staff they had were kind and caring and understood their needs. However they also often said that staff were too rushed and pressured and that this impacted upon the quality of care and support being given. One person told us, "They're really all very good, lovely girls, as long as I get the ones I like." Another person said, "The carers we have are generally very, very good. I have had the same carers for several months and that suits us quite well." People were complimentary of the staff but felt that sometimes there was a lack of consistency. The branch manager told us they had tried to ensure that people received the same carer as regularly as possible. People told us this had improved but that there were still occasions where their staff changed too much. One relative said, "Most the carers don't bother with [relative], there's one carer who does pay attention to [them] but I've been told that I can't pick and choose so I have to deal with whoever comes in. They prioritised somebody else over [relative] and it seems unfair because they can talk and [relative] can't."

During the inspection the manager told us that they had begun to alter the rotas so that people were receiving more consistent care from members of staff they liked and had developed positive relationships with. Rotas we saw confirmed that the same staff were often deployed to work with the same people and that action was taken if any concerns were raised regarding individual members of staff. People were asked which staff they liked and which ones had areas to improve upon and rotas were then adjusted accordingly. This meant that people generally received care from staff who knew and understood their individual needs.

The staff we spoke with knew and understood how to treat people with dignity and respect and most people told us that they were treated well by their regular staff. One person said, "Oh yes they certainly do treat me with respect, they're good girls. Very kind." A relative told us, "They do allow [relative] their privacy and they're very respectful." Care plans included outcomes in relation to dignity and respect for each person. However we received a concern about people being treated disrespectfully. One member of staff said, "To be honest I think it's disgusting the way they're treated. Staff are not treated with any respect and that's one thing but people aren't either. I was with a client the other day and one of the office staff was telling them to 'shut up' because they had a complaint."

One person we spoke to described problems with the flexibility of staff in relation to their care. They told us, "They won't do anything extra, they tell me they'll only do personal care. They rush around and they just want to get out. They won't even make my bed, I get put to bed in a messed up bed." We saw minutes from a recent team meeting where staff had been told it was 'unacceptable' to work outside of the care plan. Because care plans did not always contain detailed information about each person, this meant that staff were working without being flexible or able to help people with basic tasks like making tea to improve the quality of their lives. This was acknowledged in our visit on the 27 May and we were told by the Director of Care that this had been addressed with staff and they had been told they could complete simple tasks for people or ask their manager for help if unsure; this was to ensure that the staff were covered for insurance purposes.

Staff confirmed that they had an understanding of confidentiality and would not discuss people's personal

information in front of others. We saw in minutes from the recent team meeting that this had been discussed following concerns raised in the community. Staff had been reminded of the importance of keeping information confidential.

Requires Improvement

Is the service responsive?

Our findings

Both staff and a relative told us that one person did not have a care plan in their home. The relative said, "There's no care plan in place for [relative], I've had to do one myself. There's nothing in her home." A member of staff told us, "The changeover happened several months ago but not everybody has got a care plan in their house. I can end up caring for somebody with no care plan. I did not know somebody had epilepsy when I went in to provide care for them and that might have put them at risk. It seems like some of the old clients do not have care plans." Following the inspection we asked for a copy of this care plan and were later provided with a care plan held by the office for the person. During the inspection we saw that all people had a care plan in place, although some staff told us that these were not always available to read prior to commencing care. One member of staff said, "The care plans are at the office but not always in people's homes. We're not really told to read them anyway; we have to get the information from the person or their relative." The service was in the process of updating care plans from the previous management team to a new format.

Care plans were completed with involvement from the person and their relatives and included an initial assessment that looked at the type of care they required and how staff were to support them with this. While the basic information appropriate to the person's care was captured adequately in these plans, we found that they were entirely task-focused and lacked any personalisation or detail in key areas. Assessments consisted of a series of 'yes or no' questions which were then used to develop a short plan of the tasks that staff were to carry out during their visits. While the information was adequate to allow staff to follow a basic routine each time, the information was often duplicated across different plans and gave little insight into the person or how they preferred to be supported in each area. For example one person had stated that they wished to be supported with 'social and leisure activities' but there was no information in their care plan as to what this meant or how they could be supported with these.

There was no background information or social history available to provide staff with detail around who the person was, their likes and dislikes and things that were important to them. Each care plan included one stated objective but there was no evidence of how staff were helping them to work towards this. For example one person had stated they would like 'to be able to socialise more' but there was no additional information provided as to how staff could help with this. If people had conditions which may have affected their physical or psychological well-being then these were noted but no further information was provided. For example where people were diagnosed with dementia there was no information on how this affected their memory or understanding. This meant that staff may not have been able to communicate effectively with the person or understand their behaviour.

When we revisited the service on the final day of inspection we were told that the person responsible for creating these care plans had received additional training and that the plans had been assessed by a Quality and Compliance Manager who agreed that they were lacking in some important areas. While the plans were adequate to provide basic care the lack of truly person-centred information meant that there was little to enable staff to develop a strong picture of the person and understand the full range of their needs. We were later sent a copy of a more recent care plan completed following our feedback which improved upon the

original format but still required some additional work in terms of personalisation.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives were not clear on who they would complain to and the most common answer was 'the office' as the majority were not able to name the management staff. People told us that they felt no confidence that their issues would be handled correctly. Some people and staff raised concerns that the remote on-call service was ineffective as the local branch did not open until 9am, and any concerns raised outside of working hours could not be dealt with efficiently. One person said, "I'm complaining about the same thing over and over again but they're not doing anything. They keep changing the times and nobody bothers to call me. Because the on-call is in Birmingham they don't know what's going on. My [relative] has early calls and they tell me to wait until the office is open." Staff also raised concerns that complaints were not being resolved or recorded and told us they had little confidence in the office staff to handle their concerns effectively. One member of staff said, "I don't know who I'd complain to now, I've had to put in a formal complaint and I haven't received any response. I've got no confidence in things to be resolved." This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service held a log of complaints, some of which were kept in a file and others stored electronically. Seven complaints had been received and logged since February 2016 and we saw that these had been investigated and that a response had been issued to the complainant. We saw that action had been taken in response to these complaints, for example the complaint had been contacted to ask for any suggested changes. It was agreed as part of the action plan formed following the first two days of our inspection that all complaints would be held in a single file.

Inadequate

Is the service well-led?

Our findings

The takeover of the service by the new management team had been communicated to people and staff by letter but there had been little or no other communication about the changes being made. At the time of the takeover in January 2016 the registered manager had left but they had not de-registered and their registration had remained active. The new management team appointed by Sevacare had not notified the commission that the manager had left; neither had they provided details of the new management arrangements which are a legal requirement.

This was a breach of Regulation 15 of the Care Quality Commission (Registration) Regulations 2009.

At the time of the inspection there was a branch manager in post although they had not registered with the Care Quality Commission and left the service during the inspection. The manager of the service had been dividing their time between the location and another of the provider's locations with a much larger client group. We asked the manager how much time she spent at the service and she said, "At first I was here all the time but I've had to help in our other branch, I split my time between both." However some staff we spoke with did not feel the manager was visible. One member of staff said, "I couldn't even tell you her name to be honest. I don't know who's in charge." Another member of staff said, "There's a branch manager but you never see her. If I had any issues I'd talk to the care co-ordinator." Of the people and relatives we spoke with the majority were unable to tell us who was managing the service. There was a lack of clarity in regard to the amount of time the manager spent at the service and we received a variety of misleading answers when we questioned this which undermined our confidence in the transparency of the management. Following this branch manager's resignation the care co-ordinator took up the management position with a view to becoming the registered manager.

We found that the service was still in need of improvement across many areas and that the lack of a full-time dedicated manager meant that changes were not being embedded as quickly as possible. While the branch manager demonstrated knowledge and understanding of her role, the large amount of work that needed to be completed to bring the service up to a good standard meant that the current arrangement was not sustainable. This had impacted upon several areas of the service and resulted in staff feeling that their concerns were not being listened to or dealt with effectively. One member of staff told us, "It doesn't seem organised at all. I wouldn't bother speaking to the manager. Nobody helps and nothing changes." Another member of staff said, "The only person I would speak to is [care co-ordinator]. I don't know what people's roles are in the office and I don't really know who's supposed to be in charge."

Several staff commented on the perceived divide between the office and the front line staff and felt that this had not been helped by a lack of communication since the recent takeover. One member of staff said, "I haven't seen the manager for a long time, there's no real communication from the office. People die and we're not told; we're not given any support with that at all." We were told on the last day of our inspection that relationship building with staff had been prioritised over other areas such as training, but there was little evidence of this in place. We found that during the inspection, managers were quick to criticise the staff team without fully taking into account the lack of communication or support systems made available to

help them with the transition.

Since the new management had taken over the service in January 2016 there had had been one team meeting held in May, although the written minutes for this had not been distributed to staff. The first item on the agenda was 'not slagging each other off' which was not appropriate language to use in professional documents. We were provided with a typed copy of these minutes the following day. A member of staff who attended this meeting told us, "We had a team meeting two weeks ago; we felt we were being blamed for everything that was wrong." Another member of staff said, "There was a meeting but I wasn't invited because I was working. There hasn't been another one and I haven't seen the minutes." The minutes did not include items which had been flagged up for discussion in other quality monitoring tools, such as safeguarding and medicines. Not holding regular staff meetings during a period of change and instability had only contributed further to the feeling of isolation for the staff team and meant that key messages were not being communicated effectively.

There were quality monitoring systems in place to identify improvements that needed to be made across the service, but these were not always effective in ensuring that action was taken promptly to address the issues raised. The service used a computerised system to identify gaps in records and a RAG (red, amber and green) indicator would notify the manager if any documentation was out of date. Care plans and risk assessments had been updated regularly so that the service had an accurate record of which plans had been updated and which still required further input. We were shown the systems for identifying gaps in staff training, supervisions and recruitment records. While the system was robust enough to capture the information, it was not always clear what action was being taken to resolve the issues. For example the shortfalls in training were not being addressed by ensuring that staff had dates booked to bring their certificates up to date.

The manager told us they planned to send out satisfaction surveys to staff and people using the service in the future. People's folders contained records of monitoring calls that were made to check that they were happy with the service that they were receiving. The service had recently developed an action plan in response to a local authority monitoring visit and were able to show us the progress they had made towards each goal. On the last day of our inspection we were provided with an action plan and updated on the progress of each objective. While the changes that were proposed were positive, we found that management were not always clear as to why they were making these changes. For example despite presenting clear evidence that travel times between calls were sometimes insufficient, this was not agreed with. It was disputed by senior managers that the electronic records were inaccurate although this was clearly evidenced. We found we were consistently told that the issues in the service were down to the previous management team and that they had inherited a significant workload from them. While this did appear to be the case, we did not have confidence that the manager or the provider demonstrated an understanding of the work that still needed to be completed to bring the service up to a compliant standard and improve the quality of the service. This was further undermined by misconceptions in relation to the timescales they believed they had to 'rebrand' the service. Because the service was still trading as the same legal entity the history of the service remained integral to the service provision. Consequently management plans and the assumptions made in the process to rebrand the service following the Sevacare acquisition had led to a lack of commitment from management at a local and senior level when taking action to raise the overall standard and quality of care.

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

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 15 Registration Regulations 2009 Notifications – notices of change The Care Quality Commission were not notified of a change of management in the service.

The enforcement action we took:

We took urgent enforcement action on the 27 May 2016 to restrict new care packages being undertaken by the service.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were basic and did not contain enough information to offer person-centred care to people.

The enforcement action we took:

We took urgent enforcement action on the 27 May 2016 to restrict new care packages being undertaken by the service.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were basic and did not contain enough information to assess individual risks to people or establish control measures to help keep them safe.

The enforcement action we took:

We took urgent enforcement action on the 27 May 2016 to restrict new care packages being undertaken by the service.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints People told us that complaints were not always acted upon by the provider.

The enforcement action we took:

We took urgent enforcement action on the 27 May 2016 to restrict new care packages being undertaken by the service.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Electronic records maintained in respect of people's calls were not always accurate.

The enforcement action we took:

We took urgent enforcement action on the 27 May 2016 to restrict new care packages being undertaken by the service.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive regular updates to their training or sufficient supervision and appraisal to enable them to carry out their duties effectively.

The enforcement action we took:

We took urgent enforcement action on the 27 May 2016 to restrict new care packages being undertaken by the service.