Simply Together Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 8, 9, 16 and 20 March 2017. It was an announced visit to the service.

We previously inspected the service on 21 May 2015. The service was rated good overall.

Simply Together Limited provides care and support to approximately 258 adults, older adults and children. The people supported have a wide range of physical and psychological disabilities; which includes learning disabilities and people living with dementia.

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. An application had been made to CQC for a registered manager.

We received mixed feedback from people about their experience of being supported by Simply Together. People told us they thought Simply Together was not well led, and did not provide a consistently good service. People told us there was a lack of consistency in care workers ability to effectively communicate. The overwhelming theme of negative feedback provided was regarding the quality of the care workers spoken English. People told us this had a direct impact on their well-being. Comments included "I have so many carers who do not speak English or even understand English e.g. not knowing the words 'toes' or 'heels' or able to hoist correctly," "Carers don't have a clue, can't understand English or speak well ..I get very upset" and "I don't have confidence in the carers' abilities – they are unable to make a sandwich, boil an egg or make a cup of tea – I had to show them, because they could not speak English." This was supported by what family members told us. People and their relatives told us they found it frustrating that many care workers could not communicate with them. The provider and manager were aware of the level of English spoken by some of the care workers and had supported them to attend English language courses. However they continued to send care workers who they had identified as not meeting a satisfactory standard to care for people in their own home. People told us this had a negative effect on their own well-being and satisfaction about the support provided.

In contrast, people who received care from regular care workers who had been working for the provider for some time were more positive. People told us "Both of my wife's carers are excellent. We've had the same carer at night for years and the day carer has only changed four times. They have reasonably good English and they're very good at getting my wife to understand them" and
"I've got two excellent carers at the moment and their English is good so we're able to chat. Sunday is a bit iffy because they don't work Sundays."

People told us they did not always have confidence in the care workers and felt the training offered could be improved. One person told us "They've no nursing training, they've not had pad changing training and

they're no good with a wheelchair, would be better driving a tractor. Their training is virtually non-existent." We acknowledged the provider and manager had identified the need to change the training to improve the skills of the care workers. The managing director felt it was advantageous the dedicated trainer was able to communicate with the care workers in their first language.

People were not always protected from abuse as staff did not always recognise situations which had the potential to cause harm or infringed people's human rights. Where staff had informed office staff of events which met the safeguarding threshold, these were not always reported to the local authority or CQC. Incidents and near misses were not always reported by care workers to the office staff and therefore could not be investigated to prevent a similar future event.

The service did not always ensure that care workers always had the right skills and attributes to work with people. We noted some of the references for new recruits were very old which meant the service did not always have the most up to date information about new care workers. We have made a recommendation about this in the report.

People told us they were not routinely and consistency involved in decisions about their care and that care staff always sought consent from people The office staff had a good understanding of the Mental Capacity Act 2005 (MCA), however the provider's own paperwork did not follow the core principles of the MCA and care workers we spoke with were unable to tell us their understanding of the MCA. However, they were able to tell us how they would always ask someone what they would like to wear for instance.

We received mixed feedback from people about how caring the care workers were. The lack of communication skills hindered effective relationships with people and care workers. Some people told us "On the whole, the carers are very good. They always clean up if water spills and they empty the bowl but to be honest, I wouldn't stand any nonsense" and "They deal with my husband very well. He's a lot calmer now because of them, and they're very understanding of his needs and his memory loss." Other people told us "They smoke in their cars and when they come in they reek. They sit on my bed because I don't have a chair in my room and I can smell their smoke on my pillow. It's very unpleasant" and "Most of the carers are very nice but they don't always read instructions. They let themselves in because there's a key safe, instead of knocking."

People gave us mixed responses when we asked them if they felt the service was well led. We found the provider did not always ensure care workers were supported in their role. Care workers and office staff did not always received one to one meetings as regularly as the providers expected.

People told us care workers were often late and sometime they felt rushed by the care workers. We found care workers were working long hours, often starting work before 07.00and not finishing until after 22.00 They did have time off in the day, but often their working day involved a lot of travelling. We noted care workers were not always given realistic time frames to get from one person to the next.

People told us communication with the office was dependent on who answered the telephone call. We gave feedback to the provider and manager about what people had told us. The managing director and manager agreed to look into the reasons for the negative comments. The provider had made plans to change some of the systems used as they had identified improvements were required.

We noted the office had surveillance cameras at strategic places. The managing director told us this was to promote staff safety and people's data held by the service. We asked for the policy which covered the use of cameras and how the information was stored. No policy was available which covered the full use of

cameras. We have made a recommendation about this in the report.

We found there was a lack of engagement from care workers to communicate with us. We sent 25 emails to care workers and received one reply. We did receive information from ex-employees and from anonymous sources. We have made a recommendation in the report about team building.

We found breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found a breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always protected from harm because staff failed to consistently recognise, identify and report abuse.

People did not always receive their medicine as prescribed.

People's likelihood of experiencing injury or harm was reduced because risk assessments had been written to identify areas of potential risk.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not supported by staff who always received appropriate supervision and support.

People did not always receive care when they requested and did not always have continuity in care workers.

Is the service caring?

Requires Improvement

The service was not always caring.

There was limited engagement between staff and the people they supported. They did not provide people with explanations on their care and did not always seek their involvement.

People told us they could not always understand the care workers as English was not their first language.

People were not always treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were procedures for making compliments and complaints about the service. However, people felt their complaints had not been acted upon.

People had care plans to identify what care they required. However, they lacked information about the person's likes and dislikes.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was no registered manager in post.

People could not be certain any serious occurrences or incidents were reported to the Care Quality Commission. Events which should have been reported had not been.

People told us communication with the office was poor.

Simply Together Limited

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.

The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incident indicated potential concerns about the management of risk of unsafe medicines management and the lack of reporting concerns to CQC. This inspection examined those risks.

The inspection took place on the 8, 9, 16 and 20 March 2017 and was an announced visit. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

The first two days of the visit to the office were conducted by one inspector, on the third day the same inspector was joined by another inspector. The last day of the inspection was based in the CQC office. Two experts by experience made telephone calls to people who were supported by Simply Together Limited and their relatives. 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 the provider was not asked to complete a Provider Information Return (PIR). The PIR is a form that the provider submits to the Commission which gives us key information about the service, what it does well and what improvements they plan to make. We gave the provider an opportunity to share any future changes with us they had planned to make. We reviewed notifications and any other information we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

We made 75 telephone calls to people and their relatives; we received full feedback from 47 of the calls made. While at the registered office we spoke with the director of the company, the director of care and the manager. In addition with spoke with the business development officer, the in house trainer and three locality managers. We also spoke with five care workers and the reception staff. We looked at 15 care plans, risk assessments and associated medicines records for people who were supported by the service and reviewed eight staff recruitment files. We cross referenced practice against the provider's own policies and procedures.

Following the visit to the registered office we made contact with 25 staff, we received one reply.
We made contact with a further 10 people used the service and received one response.

We also contacted social care and healthcare professionals with knowledge of the service. This included people who commission care on behalf of the local authority and health or social care professionals responsible for people who were supported by Simply Together Limited.

Inadequate

Is the service safe?

Our findings

People gave us mixed feedback to tell us how safe they felt in the company of care workers. Positive comments from people included "In the main, I feel very safe with them especially with my more regular ones," "I have complete confidence in them. I'm quite happy to leave them to it whilst I go out. I know she's in safe hands" and "I feel very safe with them and they're very respectful towards me and my property." People who were less happy and felt less safe told us "I feel safe most of the time, it depends who turns up" and "I have no confidence in the majority of the carers at all."

People were not always protected from the risk of abuse. The service had a safeguarding procedure in place. However, this was not always followed. Staff received training on safeguarding people. Some of the staff we spoke with were able to provide us with their understanding of what to do if they were concerned about a person's safety or if they suspected abuse. Two staff were able to tell us they were able to speak to other agencies including the local authority or CQC if they had concerns. However the other staff we spoke with and had contact with were unable to explain to us who they would speak to if they had concerns about someone's safety. Three staff were not aware if the service had a whistleblowing policy.

On day three of the inspection we found an incident that should have been reported to the local authority and CQC. One of the incidents we identified was written in the daily notes completed by care workers. We checked the office records and no record had been made of the incident and office staff were unaware of the event. We could not be confident that staff understood what incidents needed to be reported to the office and in turn to the local authority.

The office staff were responsible for completing all referrals to the local authority upon knowledge of suspected abuse. Due to the lack of reporting with spoke with the manager about what monitoring was in place to check if appropriate actions had been taken when potential abuse was identified. The manager advised us that a number of planned changes had been proposed and hoped that in the future the proposed system would provide better oversight. The manager showed us the proposed monitoring system and if implemented that would help to ensure all safeguarding concerns were reported, however in addition to changes in the system. Staff have to be upskilled to fully understand when they need to make the office aware of potential abuse. One incident that was not reported to the office was when a person was threatened by a close relative they lived with. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as we could not be confident people were protected from abuse and improper treatment.

Prior to the inspection we were informed of an incident that involved an allegation of potential mismanagement of medicine. We had also received a number of complaints from people who were supported by the service and their relatives about incidents where mismanagement of medicine featured frequently. We examined the risk posed to people who required support with their medicines. We noted that only staff who had received training in safe administration of medicine provided support to people. We were aware a complaint had been made regarding the mismanagement of medicine; this had been accepted by the service. In one particular complaint the actions identified by the service was to ensure all staff who had

responsibility for the medicine errors were re-trained. We asked one of the locality managers responsible for the re-training if this had happened. They were able to demonstrate to us that medicine training had happened for the staff concerned.

The service had a medicine policy which had been revised and reviewed in October 2016. The policy did not make reference to whose responsibility it was to write up a medicine administration record (MAR).

We looked at a number of completed MARs. We found there was mixed practice; in some records there were gaps where support workers had not signed or recorded what had or what had not been given. In other records there was a note of why a medicine had not been given. This meant there was inconsistency in recording practice to demonstrate if the person had received their medicine at the correct time. We also found the MARs were not consistent in their detail. For instance, the detail of the information recorded on MARs should reflect the dispensing label, giving the name, dose, when and how to give the medicine. We found some medicines were just recorded by their name and dose. One MAR recorded 'Paracetamol 1', this did not give the reader clear information on whether this was one tablet, or one gram and how often it should be given. We noted many more examples where the MARs failed to provide sufficient information to ensure people received the correct medicine, in the correct dose at the correct time.

Some people were prescribed 'as required' (PRN) medicines. It is widely accepted good practice for providers to ensure staff have additional information available to them for PRN medicines. This would include why and when to give the medicine. Simply Together's medicine policy stated "Care Staff are not expected to make judgments about medication e.g. take as required" and "As required medicines – Care Staff are NOT PERMITTED to assist with these medicines unless there are specific instructions which clarify". However we found one completed MARs with "paracetamol 500 mg, only if needed". No further instructions were available to the staff to support them in knowing when to administer the medicine. In another record we found "Paracetamol 500 mg, two to be taken every 4-6 hours up to four times a day. We noted this medicine had been given, however, no time was specified on the MARs to identify when it was given. This meant the service was not working towards its own policy and it presented a potential risk to people as staff did not have sufficient information to ensure safe practice when administering medicines.

We asked one of the managers if any one supported by the service was prescribed medicine that had a potential for abuse and required additional controls. We were told no one was currently prescribed that type of medicine. However, we were made aware of someone who had been recently supported the service who had been prescribed that type of medicine. We asked if any checks or records were made of the number of medicines stocked in a person's home. We were informed no checks were made. The service had previously reported to us a medicine which required additional controls had gone missing. We checked if the incident had been reported to the police. It had not been. We asked the service to ensure it was reported as a potential theft, they confirmed this had been completed. We found no incident form had been completed by the service. This was confirmed by a locality manager.

These were breaches of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the manager and director of care about the management of medicine, as we were concerned the current practice had the potential to cause harm to people. Prior to the Inspection we received complaints from relatives of people supported by the service their family member did not always receive their medicine as prescribed. The service acknowledged medicine management required immediate improvement. The service told us they had identified this, One manager told us "Due to the number of issues

found; we have looked into a new way of working." However, the service did not always record medicine errors as incidents, near misses, or safeguarding concerns. This meant there was no record of trends in errors to identify what needed to improve. However." The service had begun to look at alternative an medicine management system to improve safety in medicine administration. We acknowledged the efforts made to date. However we were not satisfied people were protected from unsafe practices around medicine administration.

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

People gave us mixed feedback about medicines. Positive comments included "They always make sure I take my medication," "They always deal with her medication correctly" and "I get my tablets regularly." People who were less positive about how the service supported them with medicines told us "I'm partially sighted so they do my eye drops and give me my medication. If they don't come, I just don't take it" and "She has a MDS blister pack (Medicine storage system) and the manager says that the carers are not trained to use that particular sort so I deal with it."

We found a number of events written in the daily notes by care staff which should have been written up as an incidents or a near miss. This included where people had been found on the floor with injuries or where people had threatened violence towards staff. We spoke with the manager about the number of incident reports completed as this was a low number for the size of the service. They agreed the number was low. We spoke with a locality manager about an event that had been recorded in a daily note. They told us "That's a near miss isn't it." We asked the locality manager what they would expect from staff, they told us "An incident form should have been completed…we probably get more near misses than actual incidents….we probably should complete more forms." A relative told us "Mum came off the stand aid and was screaming. I came downstairs and found mum with one leg on the stand aid and one of the carers trying to hold her from falling onto the floor." We checked if the incident had been reported to the office, we found no evidence of this and no incident form.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was no system in place to effectively record and monitor medicine errors.

The service had a recruitment process in place. The main recruitment processes involved targeted recruitment in Romania. Since the introduction of recruiting from overseas the provider had changed many aspects of the recruitment process to provide a more robust system. A telephone interview was conducted via a video telephone call. Potential recruits were assessed not only on their ability to answer questions; they were assessed on their non-verbal communication including body language. All of the care workers we spoke with told us they arrived in the UK and went straight to the Simply Together head office in Chesham where they met a senior member of staff and signed a number of documents. The care workers told us they commenced training the provider deemed mandatory the day after arriving. The managing director told us new recruits were expected to successfully complete the training before a full contract of employment was offered. We noted it was usual practice for the provider to undertake some of the required pre-employment checks in this time. For example a criminal records check was undertaken in the period when training was undertaken in the recruitment files we looked at. Following a successful telephone interview potential recruits were issued with a formal letter with an offer of employment. This clearly set out expectations of the company. New staff were required to attend training with a number of documents including "2 letters of recommendation in English – one must be from your last employer – both must be on the company's headed notepaper and have been translated into the English language by an official person." Some of the recommendations were not on headed paper, however there was a signature by a member of staff to state

the information had been verified as correct. We noted many of the letters of recommendations were not always current. One recruitment file had a letter of recommendation from 2014 and another from 2011. This meant the information may not have provided a current picture of the member of staff's suitability to work with people. We also noted not all gaps in employment were routinely accounted for. We spoke with the business improvement lead, who acknowledged this.

We recommend the services seek support from a reputable source to ensure all of the required pre-employment checks are completed to ensure new staff have the right skills and attributes to work with people.

Potential risks to people had been assessed and actions taken to reduce risk were detailed when required. Risks associated with providing care in a family home had been considered. For instance, the service checked if any risks were present. One record seen commented on how dark the local area was where someone lived and reminded staff to carry a torch. Where required we noted a manual handling risk assessment was completed to identify how staff should support people to move position. Where people used equipment to help them move position, we saw clear information was available for staff on how to use the equipment. For instance what colour strap to use on a hoist. Other risks assessments included management of medicines and bathing.

Requires Improvement

Is the service effective?

Our findings

People gave us mixed feedback about the effectiveness of the support they received. Positive comments from people included "They deal with my husband very well. He's a lot calmer now because of them, and they're very understanding of his needs and his memory loss," "Most are well-trained and manage very well" and "They're very well-trained for my needs. They have no problems at all with the hoist, none whatsoever. They're very good."

The service had a dedicated person identified to undertake induction training with the staff. They had been suitably skilled and trained to deliver the training. The induction training followed the core principles of the care certificate, a nationally recognised set of standards care workers should meet. All new staff completed five day induction training and then worked alongside other staff in a shadowing capacity for three days We noted that within a very short period staff would be delivering support to people. Initially this was with another care worker supporting a person who required two care workers to assist them.

People told us they acknowledged training of staff could be improved. Comments from people included "The level of training varies considerably. The agency needs to invest in training for new staff. Mum needs help with her support stockings and hearing aid and the carers can't do these things" and "There's not much shadowing for new carers. The new staff have very little training. I always have to explain things to new people and show them what to do." Another person told us "They've no nursing training, they've not had pad changing training and they're no good with a wheelchair, would be better driving a tractor. Their training is virtually non-existent." People told us care workers struggled initially with using equipment but their skills improved with time. One person told us "They didn't have a clue at first with the hoist but now there's no problem."

The managing director informed us the service recruited many staff from Romania. We looked at induction training records for staff. We noted a number of records had comments about the staff member's ability to communicate and understand English. One member of staff's induction file had recorded "[name of care worker] has very poor English skills; I had to assist her in Romanian the whole training." We spoke with the managing director about this. They told us the trainer was able to explain the training to staff in Romanian as well as English. We had concerns that staff did not have adequate English skills at the time of employment. This was supported by further records which commented staff "needed improvement" in English. One person had been in post since October 2016 and had not been deemed as competent in communication skills. This meant the service did not routinely ensure staff were able to communicate effectively with people which potentially impacted on their care. One person told us "I often have to show them how to do things, but it takes so long because of language barriers."

This was also supported by other comments from people about staff's training. Comments included, "Very little experience," "No, don't have a clue; don't know what a dish washer is" and "I have had to show carers how to do things. Another person told us "Carers have very little experience or training." Further comments from people included "English is a real problem and they just can't understand us," "There is a language barrier. Their written English is very good but their spoken English is not as good" and "The newbies are not

too good with English. I try to make small talk but it's a struggle and I prefer people who can chat. I like a good old natter."

We recommend the service seeks support from a reputable source to ensure care workers have the right skills prior to supporting people.

Once staff passed their induction their performance was monitored on a regular basis by a quality spot check. This was undertaken by another company. The locality managers were made aware of any issues. However we noted there was a lack of evidence the issues were followed up. We spoke with the locality managers about this, they confirmed staff were always spoken to about any concerns however they confirmed they did not always record the discussion. The manager was aware of this and had put plans in place to rectify this. They had also recognised the need to improve the information recorded on a spot check and shadowing visit. The manager showed us a new form they had intended to introduce which would link the observation to training and any future learning required. The manager hoped the new form would be adopted by the board of directors in the near future.

The service had a policy on training and development which outlined the induction programme and access to on-going training. The service used a computer system to monitor what training staff had undertaken and when any update training was required. One of the locality managers was responsible for facilitating updates in training such as moving and handling, safeguarding and safe administration of medicines. They were suitably trained to deliver that training. Specialist training such as percutaneous endoscopic gastrostomy (PEG) feeding, tracheotomy and suctioning was provided by external specialist nurses.

Staff gave us mixed feedback about how supported they felt. The office staff told us they felt supported by the manager. We observed there was good communication between the manager and the office staff. The service had a supervision policy that stated "All staff should have at least one formal supervision session every three months." We checked if this was the case. We found evidence staff were not routinely supervised in line with the policy. This was also confirmed by staff who told us they did not always receive one to one meetings. The policy also stated "Employees shall only be formally supervised by staff who have been trained to do so." We asked what training the locality managers had received. There was no evidence the locality managers who were responsible for supervising staff had received any training. This was confirmed by the manager who advised us they were looking into leadership courses for the staff.

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

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.

Application procedures for this in domiciliary care services must be made to the Court of Protection. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the manager had a good understanding of the MCA and had already identified service was not complying with the MCA code of practice. The service used a form to record information about a person's mental capacity. However it stated "This form is to be used to assess whether or not the service user has mental capacity," this is in direct

contrast to the code of practice and principles of the MCA.

We noted people were asked to sign a form to confirm they consented to care and treatment. Consent was also gained from people when they required support with medicines. The daily notes completed by care workers did not always demonstrate people consented to support. The notes demonstrated what tasks had been completed. This was supported by what people told us. One person told us "Carers just come in and do their tasks and never ask my consent before doing anything." Another person told us "Not really, I rarely get asked." This was supported by other feedback we received from people.

Care staff we spoke with were unable to tell us what understanding they had about the principles of the MCA. However they were able to demonstrate how they would support people make every day decisions. For instance what clothes to wear. One care worker told us, "I always ask the person."

These were breaches of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people required support to ensure they were well fed and hydrated, we saw this was detailed in people's support plans. For instance, one person needed "A straw inside the mug or glass and leave plenty of fluids within reach and encourage fluids." Another person was at risk of malnutrition and care workers supported with the provision of a meal.

We observed office staff responded to changes in people's health. For instance one person was very poorly and had been taken to hospital. The locality manager was in regular contact with family members about the person's condition. Another person was seen to be unwell when the care worker visited. The care worker had reported this to the office and we noted office staff had telephoned the GP for an urgent visit to be made. People told us the service had supported them with changes to care visits due to healthcare appointments. One person told us "They're really good at accommodating me with hospital visits and other appointments." Another person told us I never know what time they're coming but usually they make a special effort if I have a doctor's or hospital appointment to get to."

Requires Improvement

Is the service caring?

Our findings

People gave us mixed feedback about the caring nature of care workers. The overwhelming theme of negative feedback was regarding the quality of the care workers' spoken English and their ability to effectively communicate with the people they supported. Sixty-eight percent of the feedback we received was negative. People told us this had a direct impact on their well-being. Comments included "I have so many carers who do not speak English or even understand English e.g. not knowing the words 'toes' or 'heels' or able to hoist correctly," "Carers don't have a clue, can't understand English or speak well ..I get very upset" and "I don't have confidence in the carers' abilities – they are unable to make a sandwich, boil an egg or make a cup of tea – I had to show them, because they could not speak English." In contrast to this people told us where they had a regular care worker their experience was better.

Comments from people who had regular care workers included "I feel the service is excellent as long as I have my regular carers," "Some carers are good, very friendly and I think caring" and "I am happy and satisfied with the carers." Another person told us "I feel the service is excellent. I have a regular carer who can speak English, however the new carer who stands in for my regular carer cannot speak English and it really frustrates and annoys me." Another person told us "I've got two excellent carers at the moment and their English is good so we're able to chat. Sunday is a bit iffy because they don't work Sundays."

We noted that the lack of English spoken skills had been identified by the service. For instance one carer had been identified as needing support to improve their language skills. They had been supported to attend English vocabulary training. However in a quality spot check conducted they were unable to demonstrate competency in spoken English and some three months later they had failed an English vocabulary test. The person had been in post six months and was still identified as needing support to speak and communicate in English. We asked the manager how they managed the situation. They told us the care worker was only sent on support visits that required two care workers. We had concerns how the care workers communicated in people's homes. The manager advised us the care workers would speak in English. However this was not what people told us. Comments from people included "If they come in pairs they tend to talk over me in their own language", "(Person's name) finds it difficult to understand the carers and they speak between themselves in their own language which is not very respectful and downright rude" and "The language is almost non-existent, you just get a blank look." This was also supported by what relatives told us. One relative told us "I have no confidence in the carer's ability" another relative told us "I have to be present, she [relative] doesn't understand, there is no real relationship as they [care worker] cannot communicate."

People told us they did not always feel care workers promoted their dignity and respect. Comments from people included "Some do not treat me with dignity and respect. If one carer is off sick and a new carer comes in her place, hoisting is quite considerably scary … depends on how I land on the pad placed in the bed" and "Often I am rushed with washing and dressing …carers want to leave early." This was also supported by what relatives told us. One relative commented,
"Carers not understanding English, have incorrectly fitted my mother's' hearing aids, have not brushed her teeth of combed her hair on several occasions." We spoke with care staff and asked them to explain to us

how they promoted dignity. Three care workers were unable to demonstrate they understood what dignity was, even though this topic had been covered in their training. Two care workers asked us to type the word into a translator on their mobile phone so they could understand what we were asking.

These were all breaches of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people gave us more positive feedback about how they felt care workers promoted their dignity. One person told us "They're very respectful when they're showering me. I used to be very embarrassed especially with all the different people that came but I've got a bit more used to it now." Another person told us "They have to do some very intimate things with me but they're very good. They're always very polite and respectful." This was supported by further comments "I have a shower every day and the girls are very, very good and always put me at ease" and "When they shower me, they're always very discrete and respectful. They've very good at putting me at ease."

People gave us mixed feedback about how they felt the service supported them to express their views and to be included in decisions about their care. Some people told us they had not had any contact with the office and no-one from the office had been out to see them. However on checking the records at the office we found the people who had given us this feedback had been visited. We asked the manager if they could explain why people provided that feedback to us. The manager could not offer an explanation. The managing director agreed that this would be looked into to identify possible reasons. One person told us "I have often phoned the office to request a change and on the whole, I am happy with their response."

We received mixed feedback from people about the caring nature of the care workers and the level of relationship that had developed between the person and their care worker. One person told us "Both of my wife's carers are excellent. We've had the same carer at night for years and the day carer has only changed four times. They have reasonably good English and they're very good at getting my wife to understand them." Another person told us "The carers are very nice, very polite and kind. They're really quite friendly." A third person told us "The carers are very good."

We received feedback from people that inconsistencies in care workers caused distress. One person told us "I have a regular morning carer but she's going on holiday and I have no idea who's taking over for the next two weeks. It's going to be very distressing because it'll be different faces every day." Another person told us "The carers are very good, one particularly but she's had a few days off. I've had a different carer today who was alright but I don't know who's coming tonight or what time they're coming. I would prefer the same faces." People told us the relationship improved in time and with greater understanding and skills of spoken English by care workers. Comments from people included "My main lady is good. It was a bit difficult at first and she can only use simple phrases so conversation is a bit robotic. It's not the same as chatting" and "Very nice people but sometimes I don't understand them. We work things out between us eventually."

Requires Improvement

Is the service responsive?

Our findings

People had their needs assessed prior to receiving support from the service. There was a clear process for staff to follow. People were referred to the service from Social Services and the Clinical Commissioning Group (CCG) and some people referred themselves. The locality managers were responsible for identifying if the service could meet the needs of the person referred. Information about the type of service required was provided by the referring authority. The complex care locality manager advised the process for people referred for support involved meeting the person with support from healthcare professionals when needed. For instance it was often appropriate for care workers and the manager to visit a person in hospital and to receive training from medical staff to ensure they could meet the needs of the person.

Once the service identified it had space to provide care, a full care needs assessment was undertaken by a locality manager and a full support plan was drawn up. The support plan made reference to risk throughout the document. The care plans we looked at provided good details about a person, describing their likes and dislikes about care preferences. However they were quite task focused. We found the section about the person and their hobbies and interests was rarely completed, left blank or 'none' had been written. The manager advised us since they had been in post there was a programme of reviewing all care plans. The locality manager advised us the reviews were either planned or had taken place. The service had recently introduced a one page profile which detailed the most important information care workers needed to know about what type of support was required. We acknowledged the service had identified care plans required reviews. The service expected telephone reviews to be undertaken after two weeks of the service commencing. We found this did not always happen, or if it did it was not recorded. We spoke with the manager and director of care about this. They informed us a quality assurance system had been introduced and it provided an ability to monitor if reviews took place. In addition to that the manager monitored review activity by discussing progress with locality managers at one to one meetings or performance review meetings.

Staff were required to sign in and out at each call and this information was transmitted to the office. This enabled the locality managers to see when calls were completed or delayed. Systems were in place to monitor missed calls throughout the day and action was taken to establish why it had not taken place. Prior to the inspection we had received concerns about missed calls. We saw a call was recently missed and not picked up by the out of hours team who were responsible for monitoring it. The provider had made a safeguarding alert in respect of that missed call and had brought about changes to the on call service to prevent reoccurrence.

We received mixed feedback from people about how responsive the service was to people's needs. People told us they felt when they had regular support from the same care workers they received a person centred service that was responsive to their needs. Comments included "They're very obliging and they'll do anything for me. They always offer to do extra things that aren't in my plan" and "She takes me shopping. We always chat and she's very good at getting my stuff for me in the shop." Another person told us "I have a regular carer in a morning but it's all different faces for the rest of the time." However we received a lot of feedback about lateness of visits. Comments included "Sometimes they're late but mostly they are on time.

I've had to phone the office twice to find out where they are. They never ring me," "It's not as good at the moment because our regular carer is on holiday. We're getting different carers at different times. They don't seem to respect our times. It's very frustrating when we don't know when they're coming" and "A lot of the time they're late. It's supposed to be 12.30 and sometimes it's almost 2.30 before they arrive. They take him out for his lunch and to do some shopping and 2.30 is getting very late to have lunch". People told us they were not always informed if care workers were running late comments from people and relatives included "We have no idea who's coming tomorrow; the office never rings to let us know. We would prefer a regular carer," "They're not very good at keeping the client informed with things like lateness" and "When we ring the office, they never sort our issues with lateness out."

We noted one complaint had been made as a person and their relative had been awoken by a care worker near to midnight. The relative had supported the person to get into bed as the care worker had not arrived on time. The family had not received any call from the service to advise about how late the call would be. Another relative told us "I have had a call 2 hrs and 20 minutes late without any one contacting me" another person told us "I have complained up to10 times in 18 months for no shows and lateness." A third person told us "Lateness of carers has happened over five times in the past month with no explanation." We reviewed the visits made to people in their own homes; we found calls were often later than planned. Many of the late visits occurred outside of normal office hours. The managing director told us the 'on call' service was managed by another company. We provided feedback to the managing director who was also a director of the other company about the lack of response from the on call team and lack of communication to people about late calls. They agreed to follow this up.

The service had a complaints policy in place. We reviewed a number of complaints made. We could not always tell if the complaint was active or had been closed down. There was inconsistency in recorded responses to complaints. We asked the manager to explain to us which complaints were still open. Initially they told us they treated the complaint as still open if it was not clear it had been closed down. We found the service did not always follow its policy on handling complaints. The manager advised us they had already identified improvements were required and had hoped to introduce a monitoring tool which would help them to record all stages of complaints.

We received feedback from a number of people who had made complaints which had not been responded to by the service. One person told us "I have complained many times about timings and now tend to get my wife up before the carers arrive to make things easier." Another person said "If I have had to make a complaint to the office about the carers, the response is either unpleasant and/or nothing is done." A third person told us they had made a complaint in October 2016 and they were still awaiting a reply. We checked if the service had a record of the complaint. There was no record of the complaint in the service. We also received other feedback from people that they felt complaints were not handled and responded to.

These were all breaches regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Because the service had not recognised and acknowledged all complains and it was sometimes unclear what actions had been taken to address concerns raised.

Requires Improvement

Is the service well-led?

Our findings

People gave us mixed feedback about how the service was run. One person told us "I have had problems with the office and carers on annual leave or sickness. The office needs to sort something out." Another person told us "It's been a long time since I've seen anyone from the office and never had a 'spot check' on the care staff." A third person told us "I have never had a visit from the office to discuss my care. Only a phone call in 2016. I have the impression that the office is not co-ordinated." However some people told us "The management periodically come out and check on the carers" and "There's usually two assessments per year and I usually attend with Mum." Another person told us "They've been out a couple of times to do an assessment but I can't remember how often."

People told us they did not have confidence in the office. Comments included "It's been an absolute battle all the time and still is," "It's going OK but it could be better. The office very rarely ring to let you know who's coming or when they're coming," "There's very poor communication from the office to the carers" and "There seems to be a breakdown in communication between the office and the carers. Any changes to the rota are not well-communicated at all." People were keen to tell us their perception about how the company treated staff. All the comments we received from people about the senior management team were negative. One person told us "They treat staff absolutely abominably. It's no wonder that they can't keep staff." Staff retention is difficult for the care industry. The managing director was aware staff often moved to work in care homes rather than a community based service. We acknowledge the challenges faced by home care providers.

People told us communication with the office could be improved. One person told us "Communication is very poor, there's never any contact from anybody. Nobody ever rings." This was supported by further comments from other people. For example, people told us "The office never answer the phone and never pass messages on," "The reliability of the office depends on who's there answering the phone" and "The office never phone up if the carers are running late. You tell the carers off and they say 'have the office not rung you?'." We provided this feedback to the managing director and manager for them to address.

The service did not have a registered manager in post. A manager had been appointed and had made an application to CQC to be the registered manager. The office was located in the same office block as the head office, training suite and support services including recruitment and finance team. The managing director of the company was regularly in the head office and was able to offer support to the manager. The director of care visited the office on a regular basis.

Providers and registered managers are required to notify us of certain incidents or events which have occurred during, or as a result of, the provision of care and support to people. One notifiable event is when a safeguarding concern was identified or a serious injury. We checked if we had received all the required notifications.

The service had a safeguarding procedure in place. However, this was not always followed. Prior to the inspection we had concerns the service did not always tell us when safeguarding concerns had been raised.

We had reminded the registered manager at the time who confirmed they had cascaded this to staff. On day one of the inspection office staff confirmed they had received this information from the registered manager. However, we found three incidents had occurred after that time which staff had failed to inform CQC.

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

There is a legal requirement for providers to be open and transparent. We call this duty of candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, states when certain events happen, providers have to undertake a number of actions. We checked if the service was meeting the requirements of this regulation. The service had a Duty of Candour policy which set out the expectations of the service when things went wrong. However where an event had happened which met the duty of candour requirement there were no records the required actions had taken place. This was confirmed by the manager on day two of the inspection.

This was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a number of policies and procedures in place to support with the running of the service. The manager and director of care had identified that a number of them required updating. All decisions regarding any changes to the service needed to be approved by the board of directors. A number of changes to policies and suggested different ways of working were awaiting ratification by the board. Within the care offices we noted there were strategically placed CCTV cameras. We asked the director of care for a policy which covered the surveillance. We were not provided with a clear policy on the purpose and use of the cameras. However, the managing director informed us the cameras were present to provide security and safety for staff, especially those who worked in the office outside of normal office hours, for instance after 17:30 We asked if the data was stored and for how long. We have not received an answer to this to date.

It is recommended the service seeks support from a reputable source to ensure data collected and stored is in line with the data protection act.

The service was able to tell us areas in which they wanted to change and improve. One area was the management of medicines. The service was looking into a specific system which would help to provide safe administration. However there was no evidence of why they wanted to change the system. There was a lack of records kept for medicine errors.

The service was not aware of the negative feedback we gave them about the 'on call' system, however they had already looked into a new telephone system which was due to be introduced. The new system would immediately store the telephone call onto a person's care plan file. This meant the information would be available to office staff.

The senior management team met regularly to review quality of the service, a number of audits were undertaken to drive improvement. This included a care plan audit undertaken by the locality managers. Actions required were identified. For instance one action was to speak to a care worker about how they recorded in the daily notes. However as stated previously we recognise office staff needed to ensure those conversations were recorded.

The service was aware of some of the issues we identified in the inspection. However it failed to effectively address a fundamental skill required of care workers. The service was aware that some care workers were unable to communicate effectively with older people. We acknowledged they had provided training to staff,

however they continued to send the care workers to support people who had failed English language courses and had been rated poor on spot checks. The service had failed to acknowledge the impact this had had on the people they supported. This had not been picked up as a theme from surveys and reviews.

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

The locality managers were accessible to people and staff by telephone. They were understanding, supportive and took action to deal with issues raised by people and staff. They worked well as a team within the office and felt supported by the manager. However they told us the biggest challenge for them was that support staff did not understand and speak English which made communication with staff and their job more difficult.

We asked staff about who they could talk to outside of the office if they had any concerns. We did not have confidence that staff would know who to speak with and there was reluctance in staff to give us feedback. We sent 25 emails to staff requesting feedback, we only received one reply. We were concerned that there was not an open culture within the organisation.

We recommend the service seeks support from a reputable source to look at team building.

The staff we spoke with and received feedback from told us they worked many hours during the week. One person told us they worked 84 hours in a week. We checked staffing rotas we saw that care workers regularly started early in the morning and worked until late at night. One worker finished their last call at 23:55, the call was some 20 miles away from where they lived on rural roads, which meant the journey would take a minimum of 30 minutes. However the same care worker logged in the following morning at 06.54 am. The call in the morning was to a person who lived just over 18 miles away from the care worker's home meaning the care worker had a minimum rest period of seven hours. We noted the same care worker had similar consecutive days of work rostered. We acknowledged the care worker did have a break in the middle of the day. We spoke with the locality managers about maximum number of hours care workers were allowed to work. There was no guidance or risk assessment completed for long working hours. The locality manager told us staff wanted to work the extra hours and threatened to leave if they did not get what they believed were sufficient hours. However this practice did not promote safe care for people. We had previously received feedback from ex-employees who had told us they felt unsafe when driving after working long hours. At least two staff who made contact with us advised us they had had a car accident. We noted there was a report in the 'car accident' folder which stated "reason for accident – I fell asleep at the wheel."

Rotas and schedules were in place which outlined the frequency of calls, length of calls and whether single or double handed calls were required. However we noted travel time was not routinely provided. No travel time had been allocated for a worker to travel eight miles on rural roads and in another example no travel time was allocated for a two mile journey. The service had a 'scheduling support visits' guidance, this stated "Care workers to be able to realistically travel between clients without causing subsequent visits to run late." However we noted staff had been given 15 minutes to travel 14 miles on rural roads. This meant staff were sometimes given unrealistic time frames to travel from A to B.

These were breaches of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Because the scheduling of calls did not ensure people received support when required and staff were not protected from potential risks.

The service had quality assurances processes in place, and had a service improvement plan. We provided

feedback to the service about making the improvement plan a more supportive document, which would be able to offer clear outcomes and time scales. We were informed a number of activities namely quality spot checks and the on call system were outsourced to another company. However there was no recorded audit conducted on their performance. The managing director acknowledged this on day two of our inspection. The service sought feedback from people about the quality of the service provided, however the service did not always utilise the information gathered in the feedback to drive improvements.

We found the inspection took longer than required as the service did not allow us to access their computer system under supervision. Instead, they printed off people's care plans for us to look at. On day three we requested a number of care plans at 10.00, at 13.00 we had still not received all the information we had requested. Other information regarding the support and meetings held with the manager and locality managers was unable to be found by the manager; therefore we were unable to see these.

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 11 HSCA RA Regulations 2014 Need for consent The service did not always work in line with the code of practice of the Mental Capacity Act 2005.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The service did not recognise and record all complaints made and systems to monitor complaints were not effective.

Regulated activity	Regulation
Personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The service did not always act in an open and transparent way, and did not always offer an apology when things went wrong.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service did not ensure staff who had responsibility for managing and supporting other staff had the right skills to ensure this was carried out.

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 18 Registration Regulations 2009 Notifications of other incidents The service did not always inform CQC of events it was required to do so by legislation.

The enforcement action we took:

We issued a warning notice

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The service did not ensure people's dignity was maintained. People told us care workers talked over them in their own language.

The enforcement action we took:

We imposed new conditions on the providers registration.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service did not ensure people were provided with safe care when they required assistance with the administration of medicines. The service did not ensure staff members had the right skills to provide safe and effective care.

The enforcement action we took:

We imposed new conditions on the providers registration.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service did not recognise abuse or potential abuse and it did not always act appropriately to reduce the likelihood of abuse happening.

The enforcement action we took:

We imposed new conditions on the providers registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not ensure there were effective system in place to drive improvement.

The enforcement action we took:

We imposed new conditions on the providers registration.