Castlerock Recruitment Group Ltd

CRG Homecare - Leicestershire

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

CRG Homecare – Leicester provides personal care and treatment for adults living in their own homes. On the day of the inspection the registered manager informed us that there were a total of 210 people receiving care from the service.

A registered manager was in place. 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 and associated Regulations about how the service is run.

Risk assessments were not consistently in place to protect people from risks to their health and welfare. Staff recruitment checks were in place to protect people from receiving personal care from unsuitable staff.

Calls to provide care to people were not always at the agreed and assessed times, which meant people's safety had not been comprehensively promoted to ensure they received care at the times they needed.

People and relatives we spoke with told us they thought the service ensured that people received safe personal care from staff. Staff had been trained in safeguarding (protecting people from abuse) and staff understood their responsibilities in this area.

We saw that medicines had been, in the main, supplied safely and on time, to protect people's health needs.

Staff had received training to ensure they had skills and knowledge to meet people's needs. However, more specialist training on people's health conditions had not yet been provided to allow staff to understand the challenges people had in their lives.

Staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) to allow, as much as possible, people to have effective choices about how they lived their lives. Assessments of people's capacity to make decisions were in place to determine whether they needed extra protections in place.

People and relatives we spoke with all told us that staff were friendly, kind, positive and caring. People told us, in the main, they had been involved in making decisions about how and what personal care was needed to meet their needs.

Care plans were individual to the people using the service to ensure that their needs were met, though this did not include all relevant information such as full details of people's preferences, likes and dislikes.

People and relatives told us they would tell staff or management if they had any concerns, but they were not all confident issues would be properly followed up. A number of people and relatives were not satisfied with how the service was run, with concerns about untimely calls and unresponsive senior management staff. Staff did not feel they were supported in their work by the senior management of the service.

Notifications of concern had been reported to us, as legally required, to enable us to consider whether we needed to carry out an early inspection of the service.

Management had not audited the service comprehensively in order to check whether people's needs had been fully met and to take action as needed to ensure people were provided with a quality service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risk assessments and practice to protect people's health and welfare were not fully in pace to protect people from assessed risks. People had not always received assessed care at agreed times. Staff recruitment checks were robust to protect people from receiving personal care from potentially unsuitable staff. People and their relatives thought that staff provided safe care. Medicines had been, in the main, supplied as prescribed.

Is the service effective?

Requires Improvement

The service was not comprehensively effective.

Staff were provided with training and information to meet people's care needs, though additional specialist training was needed to meet people's needs.
Staff had not received full support and supervision to assist them to provide effective care to meet people's needs. People's consent to care and treatment was sought in line with legislation and guidance. People's nutritional needs had been promoted and protected. People's health needs had not always been met by staff.

Is the service caring?

Good

The service was caring.

People and relatives we spoke with told us that staff were kind, friendly and caring and respected people's rights. People and their relatives said they had not always been involved in setting up care plans that reflected people's needs. Staff respected people's privacy, independence and dignity.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

People and their relatives were, in the main, satisfied with the staff responding to assessed needs. People's needs had not

always been responded to in terms of having timely calls and continuity of care. Care plans contained information on how staff should respond to people's assessed needs, though information on responding to people's individual preferences and lifestyles was limited. People and their relatives were not always confident that any concerns they had would be properly followed up by the service. Management staff were aware of contacting other relevant services when people needed additional support.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems had not been comprehensively audited in detail in order to measure whether a quality service had been provided and take action as needed. A number of people and their relatives thought the service was not organised or well led. Staff told us senior management staff had not provided good support to them. Legal notifications had been sent to us.

CRG Homecare - Leicestershire

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 on 27 and 28 September 2017. The inspection visit was announced. The inspection team consisted of one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert-by-experience had knowledge of the needs of people using domiciliary services.

We asked the provider to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They gave us information about how they provided a service to people.

We looked at the information we held about the service, which included 'notifications'. Notifications are changes, events or incidents that the provider must tell us about.

We also reviewed the provider's statement of purpose. A statement of purpose is a document which includes the services aims and objectives.

We contacted commissioners for health and social care, responsible for funding some of the people who used the service and asked them for their views about the agency. The local authority commissioning unit stated that there had been issues with regard to meeting the needs of people using the service, though the provider was cooperating with them on improvements to meet people's needs.

During the inspection we spoke with seven people who used the service and nine relatives. We also spoke with the registered manager, the quality assurance manager, the regional manager, and three care workers.

We looked in detail at the care and support provided to five people who used the service, including their care records, audits on the running of the service, staff training, staff recruitment records and medicine administration records.

Requires Improvement

Our findings

We saw that people's care and support had not always been planned and delivered in a way that ensured their safety and welfare. For example, a person had been assessed as needing stoma care. No risk assessment was in place to outline how this was to occur.

Another person was assessed as having a risk of pressure sores. There was a risk assessment in place which directed staff to monitor the person. The assessment included important information such as the need to apply cream to manage at risk skin areas. However, there was no information about whether there was a need to apply creams at the lunch and teatime calls. There was also no mention of the person's assessed needs as needing to wear padded boots to protect their skin from developing pressure sores. When we checked log books, we found staff had recorded they had applied cream on some occasions, but not all. For another person, the assessment stated the person's legs were prone to pressure sores, but there was no risk assessment in place regarding the need to apply creams. However, on the medicine sheet this indicated creams had been supplied but there were gaps in doing this on 16 and 17 August 2017.

This meant the person had not been safely protected from the risk of developing pressure sores.

A person was assessed as requiring support with their medicines. There was no risk assessment in place to outline how this support should be provided. It stated that a relative and a staff member assisted but did not outline who should do what and when to ensure the person safely received their medicines.

In a "personal safety risk assessment", this indicated that the person sometimes displayed behaviour that challenged the service. There was no risk assessment in place to safely manage this behaviour, should it occur.

In a person's moving and handling assessment, the equipment needed was not included in the risk assessment. The equipment provider and contract details of what tasks and actions were needed, had not been completed to maintain its safe use.

For another person who had assessed needs of risks of falling, malnutrition, and pressure area care, there were no risk assessments in place to assist staff to manage these conditions.

For another person's moving and handling risk assessment this noted that there were limitations in space in the person's home. There was no information to staff on how to safely negotiate this as there was no it

information about the equipment needed to move the person and the number of staff needed.

The registered manager and quality assurance manager acknowledged this issue and said the risk assessment would be amended and care practice would be followed up with staff.

A number of people we spoke with said that there had been proper timeliness of calls to deliver care. However, most of the people and their relatives said they had missed or very late calls from the service. One person said, "I am finishing with them. They were often seven hours late." One relative said, "On Monday we didn't have a morning call." Another relative said "We had a missed call on Sunday just gone." The relatives of two people who required double up calls told us "On the odd occasion there is only one carer that turns up and I have to help." And, "One [staff member] will turn up and we have to wait twenty minutes for the second carer. Sometimes only one carer will come and I have to help." Staff also told us that the situations had happened because the second staff member had not turned up, or turned up very late for calls.

A relative told us that their family member had to be propped up to take medicine in the early morning but staff had sometimes attended an hour later than the agreed time. This meant the person had not received their medicine at a safe time.

We looked at records of the electronic monitoring of staff calls. One staff member had started their shift 40 to 45 minutes later than the agreed time. This meant that they had been late in meeting call times for a number of calls made after or people received calls that were shorter than the agreed time. This meant there was a risk of staff rushing to complete all necessary tasks or not completing all agreed care tasks, which meant there was a risk to safe care being provided.

We looked at care records and found that a number of call times were later than the agreed time. For one person, for the agreed call time at 7am on 8 July 2017, staff had arrived at 07:49am, 49 minutes late. On 10 July 2017 the person received their call at 4.09pm., when the agreed call time was 3pm, so this call had been 69 minutes late. On 17 July 2017, the person had received their three pm call at 3.43 pm, 43 minutes late. This meant staff had not been available to apply cream to prevent pressure sores occurring.

In another person's records we found, in August 2017, that calls had been untimely, up to 47 minutes early and an hour late.

We also saw records where there were no agreed times for calls with people. This meant the calls could have been made at any time, potentially causing anxiety and inconvenience to people. It also meant that there was the risk of safe personal care being compromised. For example's people's continence equipment not being checked and changed, creams not being applied, and repositioning to protect people's skin not being done on time, adding to the risk of people developing pressure sores.

There was also evidence in staff supervision that staff had raised the issue of needing travelling time so that they did not arrive late for calls. For example, one staff member in a leaving work interview in May 2017 stated that they needed travel time between calls. Another staff member had supervision in September 2017 where this issue was raised. There was no action noted to meet this issue. We saw an audit in 2017 where the quality assurance manager had identified this issue and recorded that staff rotas needed to be planned efficiently to include travel time. However, despite identifying the issue, action had not been fully taken.

A number of people, relatives and staff said the service didn't have enough staff. One relative said, "The turnover is quite high." Another relative said, "Probably not [enough staff] because they don't seem to have cover."

This meant that people were not always receiving care at agreed assessed times. This did not safely meet their health and welfare needs of having continence care when they needed it, medication when they were prescribed it and food when they needed this.

We saw evidence of a complaint in September 2017 where a relative had complained that call times kept changing. This meant there was an impact to the person as they needed to have four hours between taking their medicine. Because of the changes in call times, this had not occurred.

These issues were was in breach of Regulation 12 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014, Safe Care. You can see what we have told the provider to do at the end of this report.

People told us they felt safe with staff. One person said, "Yes, they are caring and protective of me so I feel safe." Another person said, "I feel safe. They are brilliant. I would give them 10 out of 10." A relative said, "I feel he [family member] is safe, they are careful when they lift him."

Relatives told us that staff were mindful of people's security as they left properties secure. One relative said, "They leave it secure." Another relative told us, "We have agreed that they just knock and come in. Yes [it is] secure when they leave."

People, in the main, said that they felt safe when staff supported them to use equipment. One relative told us about an equipment accident. We told the registered manager about this and she said this would be investigated. Another person told us "I use crutches and they are always at my side to make sure I don't fall when using them." No one said that staff had ever been rough when helping them with moving and handling. One relative said, "They [staff] are never rough."

People told us that the service observed proper infection control. One relative said "They have gloves and an apron on" and a person said "When they put patches on my back they wear gloves."

Staff told us they were aware of how to check to ensure people's safety. For example, they checked that hoists and chairlifts were safe to use. We saw dates of servicing of equipment in care plans, which indicated that equipment was safe to use. We saw recording which indicated that staff had ensured the person's lifeline, used to alert in emergency situations, had been working. There was information in records that staff had ensured that people's doors were locked and keys replaced safely in the key safe.

Information was also in place with regards to checking risks in the environment to maintain people's safety. For example, of dealing with any loose rugs that people could trip on, and ensuring lighting and heating were adequate. This information assisted staff to ensure facilities in people's homes were safe. There was also information about whether fire alarms had been fitted. However, there was no evacuation plans in place should fire occur. The quality assurance manager stated this information would be included in the future.

People's safety was supported by the provider's recruitment practices. We looked at recruitment records for staff. Staff recruited by the provider underwent a recruitment and interview process to minimise risks to people's safety and welfare. Prior to being employed, they had an enhanced Disclosure and Barring Service (DBS) check, two references and health screening. (A DBS is carried out on an individual to find out if they have a criminal record which may affect the safety of those using the service).
This showed that a system was in place to ensure people using the service were protected from unsuitable staff.

Staff we spoke with had been trained in protecting people from abuse and understood their responsibilities to report concerns to other relevant outside agencies if necessary, and to report concerns to if they had not been acted on by the management of the service.

The provider's safeguarding and whistleblowing policies (designed to protect people from abuse) were in place. These informed staff what to do if they had concerns about the safety or welfare of any of the people using the service. The registered manager was aware there was a duty of care on the service to report all safeguarding concerns to enable the proper protection of people.

The whistleblowing policy contained in the staff handbook directed staff to report any issues to the management of the service. However, there was no information about how to contact relevant agencies such as the police or the local authority. The quality assurance manager said this would be included in the information. This would then supply staff with all relevant staff information as to how to action issues of concern to protect the safety of people using the service, if management did not act to protect people.

People and their relatives told us that staff had reminded people to take their medicines and there had been no issues raised about this. A person told us, "I take my medication myself but they do remind me to take it because I can forget." A relative said, "They give the tablets and wait to make sure they have been taken."

We saw evidence that staff had been trained to support people to have their medicines and administer medicines safely. A medicine administration policy was in place to help staff to safely provide medicines to people. There was information in people's care plans of any allergies to medicines, so that this information could protect people from receiving these medicines, for example if they had to go to hospital for treatment.

We saw evidence in medicine records that people had largely received their prescribed medicines. There were some gaps in medicine administration records but these had been identified in audits of the service and relevant action had been taken with staff to ensure these records were recording when people had their medicines.

In one person's medicine risk assessment it stated that the person needed to have pain killing lotion and rubbed into their fingers. However, there was no recording for this lotion on the MAR sheet so there was no evidence that this had been applied by staff. On another care plan, the medicine risk assessment stated that the person needed no support with taking their medicines. However, we saw a MAR sheet in place which indicated that staff had assisted the person with their medicine. This was contradictory and if staff had not assisted the person to take their medication, based on the information in the care plan, meant the person may not have received their medicines. The quality assurance manager said these issues would be followed up.

This showed that action had not always been taken action to ensure people safely received their medicines.

Requires Improvement

Our findings

Most people we spoke with said that staff seem to be trained to meet their needs. Some relatives did not feel that staff had been fully trained. One relative commented, "No, that is an area they could do better, they aren't trained to do suction so I have to do it." Another relative said, "When they send agency people they don't even know how to put a slide sheet on." The registered manager sent us information after the inspection visit. This showed agency staff had received training, although this did not include whether they were confident using a slide sheet or carrying out suction.

The quality assurance manager told us that tools were to be introduced to ensure that staff were competent to carry out any tasks needed. Staff told us that they had received training in the past to meet people's needs, though had not received any refresher training since. A staff member said, "I had training with the previous company before we were taken over. I would like refresher training and other training such as dealing with challenging behaviour and dementia."

Staff training information showed that staff had training in essential issues such as how to move people safely and keep people safe from abuse.

We saw evidence that staff had been supplied with some information about people's health conditions, such as training in dementia. However, some conditions such as strokes, epilepsy and diabetes had not been covered. The quality assurance manager said this would be followed up and provided to staff.

We saw evidence that new staff were expected to complete induction training. This training included relevant issues such as infection control. We also saw evidence that new staff were enrolled on the Care Certificate training. A staff member we spoke with confirmed they had undertaken this training. This is nationally recognised comprehensive induction training for staff.

We saw evidence that when new staff began work, they shadowed (worked alongside) experienced staff on shifts. The registered manager said that at the end of the shadowing period, the new staff member, if they did not feel confident and competent, could ask for more shadowing to gain more experience to meet people's needs.

Staff felt communication and support amongst the care staff team was good. However, all the staff we spoke with did not feel they had been fully supported by the management of the service if they had any queries.

Some staff told us they had not received any supervision in the past year. We saw that some staff supervision had taken place, although the records indicated that some staff had not received supervision for over seven months. The staff handbook stated that staff would receive regular supervision. The quality assurance manager stated that plans were in hand to ensure that staff had regular supervision. This will then help to support staff and advance staff knowledge, training and development.

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 told us that staff asked their consent before providing care. One person said, "Yes, they do." We saw evidence of assessments of people's mental capacity. An assessment stated that a person had dementia but was assessed as still being able to exercise choice in how they wanted to live their lives. Staff told us that they had received training in the MCA.

Staff indicated that all the people the service supplied care to had capacity to decide how they lived their lives. Care plans emphasised that staff should obtain consent in regards to all tasks. Staff had been aware of their responsibilities about this issue as they told us that they asked people for their permission before they supplied care. This meant that staff respected people's rights to make effective decisions about how they lived their lives.

People and their relatives told us that staff provided food and drink when this was needed. One person told us, "Yes they do, I am offered a choice. They remind me to eat."

People and their relatives were satisfied with the support staff provided when they assisted with food and with the choice offered. They said that food choices had been respected and staff knew what people liked to eat and drink. People confirmed that, as needed, staff left drinks and snacks between calls so that they did not become hungry or dehydrated. There was information in records that staff had left food for people between calls if they became hungry. For example, in one record, it stated that a banana had been left for the person to eat if they needed food.

We also saw information in people's care plans about the assistance people needed to eat to promote their nutritional needs.

People and relatives said that staff had responded to people's health needs. One relative told us, "When [family member] had a stomach bug, this was reported to us so we could take action." Staff told us that they had responded to people's health needs. We saw from care records that the district nurse had been involved when a staff member had observed that a person had sore skin. We saw evidence in August 2017 that a person had experienced mental health issues. The staff member had alerted the emergency services and stayed with the person for four hours until they arrived. Another staff member said that when a person had a seizure, they used the person's lifeline call device. Emergency services responded and treated the person.

We saw evidence in a person's notes in July 2017 that the person had a sore on their body. This had been reported to the office and a district nurse had been called. The day after this person was noted as being in pain at 3pm. At 7.20pm the records indicated that the person was still in pain. However, there was no evidence this had been referred to management or to medical personnel such as the GP or district nurse. The quality assurance manager stated this would be again followed up with staff members.

This showed that people's health needs had not always been protected.

Good

Our findings

People thought staff were caring. One person said, "I couldn't wish anything better. I think the world of them [staff]." Another person said, "They are very kind and patient. They are like family." A relative told us, "They speak to him [person using the service] nicely and always have a smile on their face." Another relative said, "Carers are very pleasant and friendly even when my aunt is sometime short with them."

People also felt that care workers treated them with respect and respected their privacy and dignity. One person said, "They always protect my dignity and privacy." A relative said, "They always close the door when creaming and dressing." Another relative told us, "They are very good. They always keep him covered up when washing him."

Staff gave us examples of promoting people's privacy such as covering people when helping them to wash and dress. They said they were mindful of protecting people's privacy and dignity. This was confirmed by the people we spoke with.

People explained how the service supported them to be independent. One relative said, "They allow him to do as much as he can on his own." Another relative told us, "They ask what colour t-shirt he [person] wants on. They give him choices." Care plans emphasised that people should be given choices, for example, what food they wanted to eat.

Most people told us that they have a care plan and that a review was done in the last year. However, one relative said "He does now [have a care plan]. It took them nine months to put one in place. They failed there." Another relative said that they did not have a care plan, "At the moment but we started writing one a couple of weeks ago."

A number of people said they felt involved in planning their care. One person said, "Yes definitely." Another person said, "They sat down and discussed my care needs. I was satisfied with my care plan." Another person said, "They agreed my care plan with me." A relative told us, "Yes I am involved."

The provider's statement of purpose set out that each person needed to be involved, and in agreement with care decisions. People and their relatives considered that care staff were good listeners and followed preferences. We saw evidence that people or their relatives had signed care plans to agree that plans met people's needs.

A staff handbook was provided to staff. This emphasised that staff should uphold people's rights to privacy, dignity, choice, confidentiality, independence and dignity. This also emphasised that staff should be responsive to people's race and culture and sexuality. This gave a message to staff on always adopting a caring approach towards people and their needs and preferences.

People told us that staff respected their independence so they could do as much as possible for themselves. This was also indicated in people's care plans and the recording of care provided. One logbook showed a person had chosen a meal, "Chose shepherd's pie today. This indicated that the service supported people to have choices about their preferences and how they wanted their lives to be organised.

These issues indicated that staff were caring and that people and their rights were respected.

Requires Improvement

Our findings

People told us that they had made complaints in the past. A number of people said that when they complained about issues such as untimely call times, wanting to have a staff rota or preferences for which gender of staff assisted them, office staff had not responded to these requests. One relative said, "I have complained about agency staff who don't have a clue. They still sent them the next day. They don't listen."

Another person said, "I wasn't happy how they [office management staff] spoke to me on the phone on Friday. I complained on Monday, it is still on-going." We also saw information where people complained of having untimely calls. One person told office staff that if care staff arrived on the call before 8pm again they would not be allowed in. However, this was not recorded as a complaint.

When we asked staff whether people made any complaints, they said that they did. For example, about the lack of continuity of staff, some agency staff being untrained and having their regular staff taken off them and sent elsewhere. These issues were not always recorded in the complaints log. The quality assurance manager stated that any dissatisfaction should be recorded as a complaint and this would be carried out in the future.

Staff told us they knew they had to report any complaints to the office management staff. However, they did not have confidence that issues would be properly dealt with. Some people told us they did not have a copy of the provider's complaints procedure.

The provider's complaints procedure gave information on how people could complain about the service. We looked at the complaints procedure. The procedure set out that that the complainant should contact the service. It also provided information about referral to relevant agencies such as the complaints authority and the local government ombudsman. However, it also indicated that CQC could be contacted in the event of a complaint. This is not correct as CQC does not have the legal power to investigate individual complaints. The quality assurance manager said this would be amended.

These issues were was in breach of Regulation 16 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014, Receiving and acting on complaints. You can see what we have told the provider to do at the end of this report.

People and relatives told us that staff usually responded to people's needs, when they turned up on time. They said that staff took the time to check whether there was anything else they needed before leaving. They

said staff did everything they needed. One person said, "Yes they do." A relative told us, "They always ask if there is anything else [they want us] to do." People confirmed that staff chatted to them, which they appreciated. One relative said, "They come and talk to him [name of person]. He likes that."

We saw information in people's files which indicated staff responded to their needs. For example, a card came through the post and the person asked the staff member to read this to them, and this was carried out.

People told us that they did not receive a rota regularly so they did not know which staff member was coming. One person said, "The organisation is a shambles. I need to have the same staff because they know my needs but at the moment I get lots of staff which is frustrating." One relative told us, "Sometimes we receive a rota, and sometimes we don't." Another relative told us "We used to receive a rota but not anymore."

People said that staff usually stayed for the allocated time. One staff member said a person's call time had been reduced from 45 minutes to 30 minutes for no obvious reason. When they had pointed this out to office management staff, they said nothing had been done about it. The same staff member said that another person had a bedtime call at 8pm. However, this was changed without consultation with the person to 6.30pm. The person wanted the call back at the original time but this had not been changed. Another person wanted a later call from 6.15am to 6.45am but this request had apparently been ignored by office staff. The registered manager said these issues would be followed up.

People were dissatisfied when staff were changed by the office. A relative told us, "They don't phone me if nobody is coming." There was also evidence that office management staff had let people know if staff were going to be late. A relative also recorded their satisfaction about office staff making arrangements to set up a new time when the person needed assistance.

People and relatives we spoke with told us that their care needs had been reviewed. We saw evidence of this in care plans. The review for one person indicated that a later night-time call was needed due to catheter care. There was information on file that the relevant agency had been contacted to achieve this. This meant the person's needs had been responded to.

We found that people had an assessment of their needs. Assessments included relevant details of the support people needed, such as information relating to their mobility and communication needs. There was some information as to people's personal histories and preferences to help staff to ensure that people's individual needs were responded to. However, detailed information did not include all people's preferences and their likes and dislikes, so that staff could respond to these personal needs.

At the beginning of the inspection visit, the quality assurance manager said that detailed care plans and risk assessments were not always in place. This issue had been identified and there was a plan to update this information people's needs could always be responded to by staff. We saw evidence that new forms were in place to carry this out. When this is carried out, this would mean that staff had a better awareness of people's preferences and lifestyles and be able to work with them to achieve a service individual to them.

Some care plans appeared contradictory. For example, a care plan directed staff to encourage a person to have independent living skills. However, later on in another section, it stated that care staff should prepare the person's lunch with no mention that the person could be encouraged to be involved in this. The person needed to be encouraged to eat, but in the logbook in August 2017 staff just recorded that the person did not want any breakfast. There was no mention of whether the person had been encouraged to eat to

respond to their assessed needs. The quality assurance manager said these types of issues would be identified when new care plans were set up. .

Staff told us that they always read people's care plans if they were in the person's home, so they could provide individual care that met people's needs. Two staff members said that sometimes there was no information about the person available. The registered manager said this would be followed up.

Staff said that they were not always informed if people's needs had changed, so that they could respond to these changes. For example, when two people were discharged from hospital, staff members said they had not been informed by office staff of any changes in people's care. The registered manager said this issue would be followed up. However, there was recorded evidence that staff had been informed about some people's changing needs, so that staff could respond to these new needs.

We saw that a number of recorded complaints had been made since the last inspection. There was evidence that these had been investigated and action taken. This gave some assurance to complainants that they would receive a comprehensive service responding to their concerns. A letter was sent back to the complainant setting out the results of the investigation and an apology issued if needed.

We saw evidence that the occupational therapy service had been contacted by management of the service to obtain equipment better suited to the needs of a person. This showed that the service was aware they needed to contact other agencies to ensure that people's personal needs could be properly responded to.

Requires Improvement

Our findings

A number of people, relatives and staff did not think the service was well led and well-managed. One relative said. "They are rubbish, they don't listen." Another relative said, "There are too many people [staff] coming and going." A number of people also said that the service did not carry out spot checks on the care staff.

Some people knew who the registered manager was, but not everyone. One relative informed us, "That when CRG took over the manager sent out a letter telling us she would visit everyone but she hasn't." After the inspection visit, the registered manager sent us a copy of a letter to people which outlined the new structure.

People told us that there wasn't always someone available for telephone contact if they needed them. One person told us, "They don't start until after 9am." A relative said, "They turn the phone off and you can't get through."

A complaint made in September 2017 summed up some frustrations. A relative said that their family member only wanted female staff to provide personal care but instead male staff had been sent. When they had contacted office staff, they said their view had been dismissed. Their concerns had been investigated and substantiated by the quality assurance manager, who had put an action plan in place to try to ensure the service met the person's needs in the future.

We saw that quality assurance checks had been carried out. There was a manager's check which covered relevant issues such as medicine, care records, complaints and concerns, staff training and office communication to check the quality of the care provided. The medicine audit identified issues such as missing signatures on medicine records and taking action to bring this to the attention of staff. However, some of the action noted was to discuss this with staff at supervision, when supervision had not regularly taken place.

There had been a client consultation in March 2017. This identified that 40% of calls were on time, and 55% mostly on time, which meant in total that more than half of calls had not been on time. This was noted on the quality assurance audit report of March 2017. However, based on the views of people using the service, relatives and staff, this issue had not been resolved.

In a quality questionnaire, a person had said they had no visits from management staff, and they did not

have a copy of the complaints procedure. However, there was no action plan in place to rectify these issues.

We saw a staff discussion record based on a complaint about the alleged poor quality of care supplied by a staff member. The staff member disputed this had happened but the outcome still stated that the staff member accepted their mistakes. This was contradictory. The response to the complainant stated that the person would be regularly monitored. A spot check was carried out on the staff soon after this. However, there had been no subsequent spot checks since the incident, over two months previously. This did not constitute quality monitoring. The quality assurance manager said this issue would be followed up.

A supervision record of September 2017 identified issues such as the need to have travel time between calls and the need to improve office communication and coordination. There was no evidence in place to indicate this action had been carried out.

Although an audit system was in place, audits had not been sufficiently robust to ensure that they were always able to identify and take action to improve the quality of the service to meet people's needs. For example, the audit of care records in 2017 had not identified late or early calls. A telephone review with the person in 2017 had noted that the person had an issue with the times of calls in the morning, where calls had been up to 80 minutes early and 30 minutes late. This meant that this issue had not been rectified since it was identified previously. Audits had not identified where creams had not been applied to a person who had been assessed as requiring this.

All the staff we spoke with told us that they were not well supported by the registered manager and other management staff in the office. They said that a number of management staff did not properly handle their queries or concerns. For example, office staff argued with them when they pointed out that extra calls had been added to their rotas, without consulting or agreeing to this.

A staff member said, "We don't get enough support. They don't listen…Staff are disheartened..."Everything seems to get brushed under the carpet." Another staff member said, "It's not well managed." A staff member complained that the registered manager had told staff to carry on with the call on their own when moving and handling tasks had been assessed as needing two staff.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014, Good Governance. You can see what we have told the provider to do at the end of this report.

The quality assurance report on the service in March 2017 covered issues in relation to whether the service was safe, effective, caring, responsive and well led. There was an action plan in place which covered relevant issues such as staff recruitment, more comprehensive care plans, robust as risk assessments, health and safety and the timeliness of calls. At that time, the agency was rated as requires improvement.

The quality assurance manager stated that the senior management team of the company reviewed issues where lessons needed to be learnt. She stated that the agency was planning to recruit quality assurance officers to closely monitor how the needs of people using the service were being met.

There was evidence that the registered manager had acted on some issues and brought them to the attention of staff. For example in 2017, the minutes of the meeting included issues such as staff always reporting any issues of concern to the office, and the need for staff to report to the office if calls were going to be late. Audits had identified issues that needed to be improved. For example, in a person's care records in 2017, this had identified that a person had been in pain. This had been identified by the audit as an issue

that staff needed to report.

When asked about the positives of the service, everyone commended staff. One person said, "I love my care workers they are polite, sociable, very nice girls." A relative said, "I like the regular carers, we get to know them and they get to know us."

In contrast, when people were asked how the service could be improved the majority said the management. One relative remarked, "They need to start again, I feel sorry for the girls. The management is poor." Another relative said, "It isn't the carers, it is the management." When people were asked if they would recommend the service, there was a variety of opinion of some people recommending and others not recommending the service. One person said, "Not at this moment in time. The carers yes, the service no." Some people were positive. One person said, "I would recommend them as a good agency." A relative told us, "From what I know, the service is excellent."

However, one relative told us that their family members did not always receive calls from the office of the service if staff were going to be late. The registered manager acknowledged this and said this issue would be followed up.

We did not see evidence of regular care staff meetings. One staff member said that meeting should be held regularly to discuss issues of concern and interest. We saw evidence in the weekly bulletin and messages sent to staff that the registered manager had raised the issue of the quality of care for people at a recent staff meeting. The minutes of the meeting emphasised important issues such as staff reporting that they were going to be late for calls and for staff to stay for the full time of the call. This indicated the registered manager had been proactive in trying to ensure a quality service was provided to people.

We saw some evidence from on-call notes that office management staff had called a person when staff were going to be late.

There was evidence that some staff had received visits by senior staff to observe the care staff at work, which are called spot checks, and reviewed the care they provided to ensure this was of a good quality. However, in the supervision matrix, there was evidence that a number of staff had no spot checks to assess whether their performance met the needs of people using the service. The quality assurance manager said this issue was being actioned to ensure all staff had spot checks.

In records, we saw that incidents that the service had a legal duty to report to CQC had been carried out. This meant we had been made aware of incidents, so we had comprehensive information to assess whether we needed to carry out an early inspection of the service.

Staff had been provided with information in the staff handbook as to how to provide a friendly and individual service with regard to respecting people's rights to privacy, dignity and choice and to promote independence. There was evidence from staff meetings that the management of the service expected staff to provide professional care to people, and to meet the individual needs of people.

There was a monthly award recognising the best care provided to people by a staff member. This initiative recognised staff that provided quality care provided to people. This provided further encouragement for staff to provide quality care to people.

Staff confirmed that essential information about people's needs had not been communicated to them, so that they could supply appropriate personal care to people. We saw some evidence that this had been

carried out in the records we looked at. However, the comments by staff indicated that a robust system was not in place to ensure staff had up-to-date knowledge of people's changing needs.

All the people and their relatives told us that they had care plans kept in people's homes so that they could refer to them when they wanted. They confirmed that staff updated records when they visited.

We saw evidence of quality questionnaires where there had been a telephone check with people or their relatives to get their views on whether the service was meeting people's needs. There was also evidence of a recent survey that had been sent to people using the service. This asked people what they thought of the care and other support they received. People were mainly positive about the service. This covered issues such as the timeliness of calls, the quality of care supplied and the attitude of care staff. This meant people had the opportunity to state their experiences of the care and whether this needed to be improved.

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had not comprehensively kept people safe as risk assessments to promote people's safety were not detailed enough, and calls were not delivered at assessed and agreed times to protect people's health and welfare needs.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints All complaints made had not been recorded as complaints and investigated with action taken as needed to resolve the issue for the complainant.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance An effective quality assurance system was not in place to ensure that the service met the needs of people. Some people, relatives and staff did not think the service was well organised or well led.