C M Community Care Services Limited

CM Community Care Services Limited - 30 Waterloo Road

Inspection report

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Date of inspection visit: 22, 26 and 28 May 2015
Date of publication: 10/08/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

We undertook an unannounced inspection of CM Community Care Services Limited - 30 Waterloo Road on 22 May, 26 May and 28 May 2015. At the last inspection in July 2014 the service was meeting the regulations with all of the areas that we looked at, but was rated overall as "requires improvement".

CM Community Care Services Limited - 30 Waterloo Road provides personal care for people in their own homes. At the time of our inspection there were approximately 350 people receiving the service.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

Some of the people and relatives we spoke with praised the service, but some people and relatives expressed concerns about the safety and quality of the service provided.

Some people and relatives told us the service was safe, while others felt it was not. People told us about specific instances where they had not felt safe with staff.

Staff were not always on time for visits and this effected people negatively. Call times were sometimes cut short. Staff's ability to be on time and complete full visit times was sometimes affected by them being given additional visits to complete.

We could not be assured that people always received the medicines they needed to support their health, as medicines administration records showed significant gaps in people being given their medicines.

Staff did not always use appropriate infection control procedures while providing care. However, staff we spoke with were aware of proper infection control techniques.

Some people and relatives felt staff were skilled at their jobs, while others did not. Staff told us they had received adequate training.

Most people said staff respected their rights. The registered manager demonstrated that they knew what steps to take if they suspected a person's ability to make decisions was declining.

While some people were provided with adequate food and drink by staff, some people's regular food intake was affected by inconsistent visit times.

Some people found staff to be caring, while others had raised concerns about staff attitude. Some people told us they felt listened to by staff and management, but others told us that the provider was not responsive to them.

Some people told us that staff respected their dignity and privacy. However, we were given examples of when staff had failed to support people's dignity. People told us they sometimes felt rushed by staff.

Some people told us that the staff who visited them frequently changed and so staff were less aware of their needs. Other people received care which suited their needs.

The provider advertised their complaints process to people, so they would know how to raise an issue. People gave us a variety of views on how well the provider handled complaints.

People held differing views as to whether the service was well managed. We found that the provider's auditing processes were not effective in identifying some of the issues we discovered during the inspection. We found that some care records were not always consistent or updated.

Staff told us that they were well supported in their roles by the management team.

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

The overall rating for this provider is 'inadequate'. This means that is has been placed into 'special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made
- Provide a clear timeframe within which the providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measure will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection

Summary of findings

will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

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 and relatives gave examples of instances where the care provided by staff was not safe and had affected people's well-being.

We could not be assured that people received the medicines they required to help maintain their health.

People and relatives said that staff did not always adhere to good infection control practices.

Is the service effective?

Inadequate

The service was not consistently effective.

Some people and relatives expressed concerns about the standard of training received by staff.

Consent to care was appropriately gained by staff from most people and staff where aware of how to protect people's rights. The manager knew what steps to take should they suspect someone's ability to make decisions was declining.

Due to inconsistent and unevenly spaced visit times, some people did not always eat enough food throughout the day. Other people were well supported by staff to eat.

Is the service caring?

Requires improvement

The service was not consistently caring.

Some people were complimentary about how caring staff were, while others told us that staff were not always caring.

People and relatives gave us differing views on how responsive the provider was. Some told us that the provider responded well to them and others said that the provider did not deal with matters they raised appropriately.

We were told of instances where people's dignity and privacy were compromised by staff. People and relatives told us that visits were sometimes rushed.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Some people received care which suited their needs while other people did not.

Some people told us that they received visits from different staff who were not so familiar with their needs.

Summary of findings

Some people told us that the provider was flexible in how they delivered support, which had a positive effect.

Is the service well-led?

Inadequate

The service was not well-led.

People and relatives gave us a variety of responses about the quality of the management of the service. Some people were complimentary while others were critical about how the service was run.

The provider's auditing processes were ineffective in identifying some of the issues we had found during the inspection.

We found that some people's care records were inconsistent and had not been updated. Provider audits had not identified these issues.

CM Community Care Services Limited - 30 Waterloo Road

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 22, 26 and 28 May 2015 and was unannounced. The inspection was carried out by two inspectors and three experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we looked at the information we held about the service. This included statutory notifications, which are notifications the provider must send us to inform us of certain events. We also contacted local authorities and the local clinical commissioning group, who monitor and commission services, for information they held about the service. We had received a number of concerns from people, relatives and staff about poor care provision, poor staff training, poor time keeping by staff and the provider having an unhelpful approach to issues of concern raised with them.

During our inspection we spoke with 11 people who used the service and 24 relatives. We also spoke with the registered manager and eight other members of staff.

We reviewed the care records of 30 people who used the service, six staff records and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People and relatives gave us mixed responses when asked if they felt the service was safe. One relative told us, "Yes, [person's name] is safe on the whole". Another relative said, "[Staff] are lovely and we feel safe and I never had any worries that they are not trustworthy". However, one person told us, "Yes I do feel safe with some of them and some I have to refuse them coming to me". This issue had been raised with the provider and appropriate action taken. Other people and relatives raised concerns about the safety of some aspects of the care provided.

One relative told us of an incident involving the use of a hoist, a piece of equipment used to assist a person to move. This procedure was carried out contrary to the person's risk assessment. They described how, during the lift, the person had slipped resulting in injuries. The relative informed us that this matter had not been reported to the local safeguarding authority, as required. Based on this information, we referred this to the local safeguarding authority as they lead on investigating such matters.

People and their relatives told us that staff not being on time for calls, and not staying the full duration agreed for calls, was an area of particular concern. One relative of a person told us, "[Staff] are generally pushed for time". Another relative told us that care was often "cut short" so that staff could quickly move onto the next visit. They told us that staff were instructed by the office to complete their relative's visit quickly, so they could get to the next person.

A relative told us, "Yes, I complained about the schedule over the last two to three weeks. It has been all over the place. Tea-time they have been coming late and for the bed-time call early and only leaving two hours between those two calls which are not enough". Another relative said, "In the last 6 months I have rang the office three times [about] timings of the calls and I have complained to the carers".

One person told us, "No, [staff are] not always [on time]. It is the ones that rush in and out and only stay 15 minutes and I say to them that the office said it is 30 minutes and the office also said that if they have to stay longer than the 30 minutes that they will get paid for that. The office does not know what is going on". A relative commented, "[Staff] do leave early five or 10 minutes and this happens more often than not". Another person told us, "They were very late this week and the tea time call is the worst. I am out of bed at 12 noon and I like to go back at 5 pm, but sometimes they come at 5.45 pm or 6 pm and it is too long for me to be sat in the chair". A relative told us, "We have only one visit a day and they are often late and sometimes finish early".

Two people told us that staff had, on occasions, missed visits. One person told us, "They have missed three or four occasions. Once I was annoyed that [the person's name] had no access to fluids for the night; the emergency lifeline was not around [their] neck".

Staff told us that they did have enough time for travel and that they were only late for calls occasionally, which did not match the experiences of some of the people we spoke with. One staff member said they could be late when they were given extra visits to complete. One person we spoke with confirmed this happened. They told us, "My morning calls are ok, but the tea time one could be 30 minutes plus late. I have asked the office about this and they say that they are going to sort it out. The girls say it is because, if they get a new call, they are put in before me". Another person said, "They generally arrive on time, but can arrive late if they have been given extra jobs to do by the office". A relative told us, "The trouble is the carers are given more calls on top of their regular work and expected to do it".

One relative told us, "Quite often they are early and equally late. I don't get any phone calls. They are supposed to turn up at 07.30 am. They call at 08.15 am and finally turn up at 09.00 am, by which time [the person] has soiled [themselves]. They also do not stay for the full time. The office should call, but they never do". Another person said, "They should come at 9 pm but sometimes they don't turn up until 10 pm and even 11pm".

We compared 14 people's agreed visit times with timesheets completed by staff. We also checked service agreements with the local authority to ensure the accuracy of the agreed visit times shown in people's records. We found that 12 out of 14 of these records showed a significant number of visits to people did not start on time and did not always last for the agreed length. Some people told us that they were not always contacted to explain their visit would be late, which created a further impact on them. One person told us, "Yes, the office sometimes rings, and if the carer knows they are going to be late they ring the office and tell them, but the office does no always ring to tell me".

Inadequate

Is the service safe?

These issues demonstrated a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people and relatives told us that they felt staff were, "Trustworthy". We looked at six staff recruitment records to see what checks had been carried out by the provider. We saw that appropriate checks, including police checks, were carried out. We saw that one member of staff had been dismissed from their previous employment. The registered manager told us that they had discussed the matter with the staff member. However, there was no risk assessment in the staff file to show proper consideration had been given to the circumstances in light of their current employment.

People and relatives gave us differing responses as to whether staff gave appropriate support with medicines. For example, one person told us, "The carers give the tablets. We had no problems". However, other people told us they did not always get the medicines they required. One relative told us that one person sometimes told them they were not given their tablets and the relative had found medicines left "on the side". The relative informed us that the medicines for this person were supposed to be administered by staff to ensure they took them. Staff we spoke with told us they had received medicines training and felt confident in administering medicines.

One relative told us that there were gaps in a person's medicines administration records, which meant they could not be sure if they had been given the correct medicines by staff. We looked at people's medicines records to assess whether people received their medicines as prescribed. We saw that a number of records had significant gaps in them. This included gaps in the application of topical creams. We could not be assured that people received the medicines they required in order to keep them well. We looked at people's care records to see if listed medicines matched those shown in their medicines administered records. We found that some records did not match. Staff told us that they did read people's care records to understand their needs, in addition to speaking with people and relatives. This meant that staff received inconsistence written guidance about what medicines people required.

A relative told us that staff had attempted to "cover up" a mistake they had made with medicines by changing the medicines record. As a result of the seriousness of this allegation and other concerns raised in respect of the care of this person, we referred this to the local safeguarding authority.

One relative told us that a person needed topical cream applied to their legs. They said that staff were applying these creams while the person was sitting on a commode. This presented a risk for transferring infection. A relative said they had to speak with staff about them not using personal protective equipment (PPE), such as aprons. This relative told us they had raised the issue on a number of occasions. This relative told us that staff often turned up in "grubby" tops and had to be reminded to remove their coats before providing care. They told us, "[Staff] have no idea about basic hygiene and infection control". Another person's relative commented, "I wish [the staff] had clean tunics". Unsuitable and unclean staff clothing presents a risk of cross infection.

One relative told us, "Some of the carers are very good and some are not. Some are not so particular and they don't get themselves prepared and they leave the soiled rubbish in the carrier bag with faeces and faeces in the wet wipes bag". Another person told us that they had discovered one staff member was disposing of urine from a commode down a sink, rather than into a toilet. Incorrect disposal of waste heightens the risk of cross infection.

We asked staff about proper infection control procedures and they gave accurate answers. They told us, and we saw, that the office was stocked with PPE, such as gloves and aprons. Staff told us they did use PPE appropriately. The provider also had an infection control policy and guidance in place. This meant that there was no reason why staff should not be using appropriate infection control procedures and equipment while caring for people.

Inadequate

Is the service effective?

Our findings

People and their relatives gave differing views on the skill levels of staff. One relative told us, "I am satisfied with the care". Other people and relatives told us that staff did not appear to be properly trained. For example, one person told us, "I have refused to have a few of them and some of the new young ones do not know what they are doing and I don't think that they have had enough training". A relative told us, "It is only when the new people are training and they come with two others and they shadow them. I don't think they have enough time for the shadowing". Another person said, "Some of the training could be more in-depth". Another relative said, "It is only the new ones I have concerns about as they don't seem to have had enough training". A further person commented, "They are not as well trained as the previous council care staff". A relative told us, "Some are well trained, other are not. They often put new staff together and we are not happy with this because they do not know what they are doing".

One person said that they had to raise an issue about staff not being competent to use two different pieces of equipment used to help them move. One relative told us, "Hoist; not all the carers have the right skills and some ask me for directions on how to do this… some of the carers are not good at hoisting".

We examined staff training records. These were inconclusive, as we could not determine when some staff had received updated training in some subject areas. This was because the record only showed that training had been "completed" and was not dated in a number of instances. There was no provision on the staff training record to show which staff were due to renew certain training. This presented a risk due to the size of the staff group.

However, training records did show some specific data for staff having completed moving and handling training. Over 130 staff were listed on the matrix of which 16 were shown as not having done moving and handling training and 26 having not updated their training in moving and handling since 2013. We spoke with six staff, three of whom were new. All staff told us they had received recent training in important areas of care, including how to assist people to move. Staff also told us that induction training and shadowing opportunities were adequate. Staff views did not match the views of some people and relatives.

These issues demonstrated a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people and their relatives said that staff sought consent before providing elements of support. However, some people and relatives said consent was not always sought. For example, one person told us, "The first thing [staff] do when they come in is use my phone. They do not ask me and annoys me; they could ask". A relative told us that a person who had more complex care needs was not spoken to directly by staff and were not given the opportunity to respond.

Staff demonstrated a good working knowledge of issues in respect of people's ability and right to make their own decisions. The registered manager also demonstrated knowledge around the law about people's rights and knew what steps to take if it appeared that someone's ability to make decisions was declining due to, for example, progression in their illness.

Two relatives said that, due to staff not turning up at the agreed times, visit times were sometimes not evenly spaced. Some people told us that this affected their mealtimes. For example, they were supported with breakfast at one visit and the next visit would occur shortly afterwards, when they were supposed to be supported to each lunch. This meant they were sometimes not hungry by the lunchtime visit and did not wish to eat. One relative told us, "My main complaint is that [the person]'s 9.30 am call when they prepare her and [the person] has her breakfast at 10 am they then come and give [the person's] dinner at 12 noon and once they came at 11.45 am. She is not hungry and the calls are too close together and I have rung twice and it gets better, then it goes back". We highlighted the issues regarding poorly spaced visits to the registered manager, which they said they would address.

Records supported the fact that visits were not always carried out at the agreed times and were sometimes close together. This meant that there was a risk that some people's food intake could be affected by staff's poor time keeping. Another relative told us that their relative was, "Not fed well". Another relative told us that staff did not always ensure their relative ate enough. They said, "Once I saw sandwiches in the bin. [The person's] care plan states that [the person] had to be encouraged".

Inadequate

Is the service effective?

One person told us that the staff were not always able to cook what they chose. They told us, "I show the list [of food] to the carers, but some say that they do not know how to cook that and that happened quite a few times and two-three weeks ago, because [the staff member] could not cook I only had a sandwich".

One person told us that staff did stay the amount of time it was required to support one person to eat well. They told us, "They stay the right of time as [person's name] needs to be encouraged to eat". Other people told us that staff provided them with a choice of food and ensured they had something to eat and drink. A relative told us, "Carers always tell me if [the person] has not had much food to eat".

People we spoke with told us they or their relatives arranged their healthcare appointments and so they did not rely on staff to assist in this aspect.

Requires improvement

Is the service caring?

Our findings

People we spoke with gave us differing views on staff and how caring they were. One person told us that staff were, "A bit arrogant" and that they had to request that some staff did not attend visits with them. One relative said, "We have four carers who are outstanding, but we dread the weekends when we get the other carers". This was echoed by a relative and another person who said, "We have two carers who are very good, but the others are very poor and just don't know what they are doing". Other people also told us they had to request that some staff not visit them.

However, some people we spoke with were complimentary about staff. One person said, "I get on with most of them and have a laugh". A relative told us, "Yes, they are lovely and very kind". One person told us, "They always say good morning and they always say cheerio and they are always well mannered". This suggested a variety of standards in the caring offered by different staff.

Some people told us they felt listened to. One person said, "Yes, they do listen to me and I have got the office phone number by my side". Other people told us they were not listened to. For example, one relative told us, "I think the office is not responsive. I have called and asked them to change an hour later in the morning call. The office keeps on saying they will do it, but nothing happens". Another relative said, "I have to ring every day to the office on timings and have been fed up as there has been no response".

People's experience of the process of planning care and being involved was variable. Some people described how they were visited by the manager or a senior member of staff and their care was discussed with them. Most of the records we looked at supported the fact that staff had discussed care planning with people. Other people told us that social services had completed their care planning and they had no input into this. Two people told us that staff had turned up on the first day to deliver care without this having been properly planned. They told us that they had, however, been part of a subsequent care planning meeting.

One person described how their dignity had been compromised by some staff and that the local safeguarding authority was looking into this matter. A relative of another person told us that the person's dignity was compromised by staff while they used a commode. They told us the person was reluctant to use the commode as they were not given "space" to do this in private by staff. They told us staff applied creams to the person's legs while they were sitting on the commode. This had caused discomfort and distress to this person. As a result of this, and other information we were told about this person's care, we raised a safeguarding referral with the local authority.

Other people and relatives felt that, while the majority of staff were respectful, some staff did not deliver care in a respectful way. Two people commented that a few staff were less experienced and lacked sufficient training to maintain respect throughout the visit. One person said, "They rush me to get on to the next client". A relative commented, "Most of the time [the person] is safe, but carers rush and do not give the allocated time for care". One relative told us that rushed visits meant that opportunities to develop a person's independence were limited.

These issues demonstrated a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other people were more positive about the way staff protected their dignity. One person told us, "They give me a good wash down every morning and they cover me up with a towel. I have never been embarrassed". A relative explained how staff were sensitive to gender requirements. They said, "On occasions we have a male carer, but when personal care is given he either comes out of the room or turns his back. There is always one female carer and on the whole we have not had a male for ages". A relative of another person told us, "Most do show [respect for dignity and privacy] and I stand and watch over them. They use a towel to cover [the person]". One relative described how staff followed their instructions in order to understand the needs of the person they were supporting. This included using the best communication methods in order to understand the person's choices.

Requires improvement

Is the service responsive?

Our findings

Most people told us that the care they received suited their needs. One relative told us, "The care is specific to [person's name]". Another relative told us, "The care is absolutely suited to [person's name] and it is working well".

However, other people told us that staff's understanding of their needs varied. Some people said they felt this was as a result of them not receiving visits from a consistent staff group. One relative told us, "A couple of carers are regular otherwise we get different carers". A relative told us that staff did not respect one person's preferences. They told us, "[The person] would like a wet shave but they will not do it for [them]". Another relative said, "The night [staff] understand [the person] and know what [the person] likes. The ones during the day do not understand [the person] because they don't get to know [them]".

Some people told us that communication between them and the provider could be improved. One person told us, "The communication in the office is not good". A relative told us, "The office is never responsive or gives feedback". We discussed the way in which some staff responded to people with the registered manager, who agreed to address this aspect.

Some people were more positive about the responsiveness of the provider. One relative explained how the service had responded to a request for an adaption in the visits they received. They told us, "The private carer is going on holiday and I have spoken to the office and I am going in and they are going to work out a revised package for three weeks to cover [person's name]'s needs". They also told us, "They changed the 11am call to 10 am after we requested it. It is working very well". Another person explained how the service had supported their relative after a stay in hospital. They said, "When [the person] went into hospital for a week and came home the care package was seamless and we had no problems".

Some people we spoke with told us that they had raised complaints with the service. People told us that some of these complaints had related to staff attitude and that the provider had arranged for the relevant staff not to visit the person again. Some people told us the service did not react well to complaints. One person said, "I don't always complain as it stressed me out… I am not sure my calls always get passed on and you feel that they don't take me seriously" and "They don't always ring me back and when I complain they say they will sort things out, but they do not". A relative told us, "I have a book (care plan) that is taken every week to the office, where I have put the concerns, but so far no response from the agency. There had been no surveys, feedback or response from the office".

Other people told us that the provider had reacted appropriately to their concerns. For example, one person told us, "I did complain once a while ago when the lunch [staff member] did not turn up and I rang the office and they did apologise, but it has not happened since".

We saw that the provider had an appropriate policy concerning the handling of complaints, including the timing of responses to issues raised. We found that the registered manger had completed appropriate enquiries in relation to the complaints we saw recorded. However, the response letters sent to people were not dated, so the timeliness of the responses could not be established.

We asked people if they knew how to raise a complaint about the service. Most people indicated that they would, and had in the past, contacted the service's office to discuss issues. We found that the service user's guide, given to people when they first started using the service, contained information about the provider's complaints procedure. We did, however, find that some information about other agencies was out of date. This included incorrect contact information for the CQC.

Inadequate

Is the service well-led?

Our findings

Prior to our inspection, we had received a number of complaints from people and relatives about the culture of the management at the service. Some people told us that the provider did not react positively to them. One person said that the management team were dismissive and "aggressive". We raised this issue with the registered manager who said they would address this with relevant staff members.

Some people told us they felt the service was well-led. They told us, "Yes, I think they are well-led" and "Yes, I think it is well managed". Other people were less positive about how well managed the service was. One person said, "I don't think that it is the best organised. It could improve if they talked to the staff". Another person said, "There is nobody in the office. They have too many clients and nobody has come to see how things are". A third person said, "We are sick of ringing the office asking where our carer is. If we complain enough the manager will come out, but nothing happens".

One person told us that there was a communication issue at the provider's office. For example, they had raised an issue concerning staff training needs in respect of a piece of equipment, which the management were not aware of when the person spoke with them recently. "A lot of the problems are communication" and "There's lots the office don't know about". Another person said, "The communication with both the users and carers is poor". A relative commented, "The communication in the office is bad between them and the service users". A further person said of the management team, "They respond, but they can't keep it up".

However, other people and relatives we spoke with were more positive about communication and their experience of ringing the service's offices. One person told us, "I get on well with the office". A relative told us, "It's easy to get hold of the office. I just ring and tell them what I want and they do it. They always ask if I'm happy".

Prior to our inspection whistle-blowers had contacted us and told us morale among staff was low and there was a high turnover of staff as a result. The high turnover of staff was confirmed by some people using the service, who told us they had received a number of different staff. One relative told us, "They have a high turnover of staff". Some people told us that staff appeared to be happy in their work, while others said it was apparent that some staff were not. One person said, "Probably half are and half are not". Another person told us, "Some of the staff are happy and some are not". A further person said, "Staff don't seem happy. They are busy and have emergency calls and they get stressed out".

However, staff we spoke with during the inspection told us they felt well supported by the management team. They told us that they received regular meetings with supervisors. They said the management team communicated with them, often via a 'memo' system, so that there were aware of any developments with the service. One staff member told us, "I love my job".

We saw examples of surveys which had been completed by people and their relatives. The surveys were dated December 2014. We also saw that people's view of the service was gathered during their care review meetings with senior staff. The provider had analysed recent surveys to identify where there were issues. While most responses showed that people were happy with the service, a number of people had raised concerns about staff time keeping. The provider's analysis showed that 280 surveys had been sent out and 106 responses had been returned. Some of the people and relatives we spoke with as part of our inspection could not recall receiving a survey from the provider.

We spoke with the registered manager about how they audited visit times. The registered manager explained that they had been implementing a new system, since March 2014, where staff telephoned in and out of visits to record these times. The registered manager told us that they had experienced problems with the system, which they were trying to resolve. The registered manager was unable to demonstrate that an effective replacement auditing system had been put in place while system issues were being addressed. The issues we had discovered in respect of late and shortened visits had therefore not been identified by the provider. This meant that these issues were not being appropriately addressed, despite them having been highlighted during our previous two inspections.

We also found problems with some of the time sheets entered by staff in order for them to be paid. Some entries on these sheets showed that staff had finished work at one person's home and started at another person's home with no time elapsing in between calls for travel. We saw, from

Inadequate

Is the service well-led?

the postcodes of the relevant people, that this was not possible. We had also received reports from one relative that staff had falsified timesheet entries to show they had arrived 15 minutes earlier than they had and had challenged staff about this. These issues had not been identified by the provider through the use of an effective auditing system.

Although we saw that accident and incident records were correctly completed by staff, the registered manager agreed they had no system to trend incidents. Given the significant numbers of people using the service and staff this could affect the provider's ability to identify trends and related issues.

The provider had ineffective auditing systems to ensure that people's care records were updated and provided consistent guidance to staff about people's needs. The registered manager told us that the times stated in people's care records could not be relied upon, as these may have changed. They said they could not be sure that the local authority service agreements contained in people's care records were current.

We found other examples of inconsistent care records. For example, some people's care records showed a need for differing moving and handling equipment across different records. A number of people's medication administration records were not consistent with their care plans and master medications records.

We found that staff completed a daily body map in people's log books. We saw that some people had areas of reddening skin, but there were no entries in the log book or in daily entries to show any actions taken in relation to this reddening. We saw a lack of recording of action taken where a person was noted to have a "hand-shaped" mark on their leg. A senior member of staff contacted the relevant staff and said this had not been as a result of any suspected abuse. Staff told us they would inform the management team of any issues with people's skin.

One person's care records showed that they were at risk of hydration and swallowing. The record showed: "Staff trained in hygienic food preparation; no personal care items to be taken into a food area". There were no control measures which related to the person's actual risk factors of dehydration or choking. We also found that moving and handling risk assessments lacked personalisation and detail. These risk assessments only listed what equipment was used and how many staff were required to assist.

There was a lack of specialist care plans. For example, one person had epilepsy, but there was no care plan in relation to this. One person was said to scream if they felt frustrated. There was no explanation or guidance regarding what might trigger this person to become frustrated or what staff could do to support this person in this respect. There was a lack of care planning for some people said to be at risk of sore skin. One person required staff to assist them with putting on a body brace, but there was no care planning around this despite the registered manager telling us that concerns had been raised by a member of day centre staff about how staff were doing this.

There was a lack of guidance in relation to how staff should administer 'as required' medicines to people who occasionally needed these. These medicines included inhalers and pain relief.

We found that a staff file was lacking risk assessments in respect of information they had provided at the recruitment stage. This person had been dismissed from their previous role. The registered manager was able to detail a conversation held with the staff member about why they had been dismissed, but there was no accompanying risk assessment on their staff file.

The provider's own audits had not been effective in identifying the issues we had found. We found a failure by the provider and registered manager to complete and sustain improvements in relation to issues identified at previous inspections.

These issues demonstrated a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People who use the service were not always treated with dignity and respect.**

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 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use the service do not always receive care provided in a safe way.

The enforcement action we took:
We have served a Warning Notice on the Provider and Registered Manager for breaches of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014. The Warning Notice provides a deadline of 4 August 2015 for its provisions to be met.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not always use systems or processes which ensured the proper assessment, monitoring and improvement of the quality and safety of the service provided, including the management of risks to people and the keeping of accurate, complete and contemporaneous records in respect of each service user.

The enforcement action we took:
We have served a Warning Notice on the Provider and Registered Manager for breaches of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014. The Warning Notice provides a deadline of 4 August 2015 for its provisions to be met.