Housing & Care 21

Housing & Care 21 - Sheffield

Inspection report

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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 carried out this inspection over three days, on 08 September 2015, 01 October 2015 and 02 October 2015 and it was an announced inspection. This meant we gave the provider notice that we were going to carry out the inspection. At the last inspection carried out in March 2014, we found the service to be compliant with the regulations inspected at that time.

Housing & Care 21 – Sheffield is a domiciliary care service that provides personal care to people living in their own homes in Sheffield. On the day of our inspection, there were approximately 3,000 hours of care provided each week by the service.

It is a condition of registration with the Care Quality Commission that the service has a registered manager 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 2008 and associated regulations about how the service is run. The person who managed the service daily was not the person who was registered with CQC as the 'registered manager' but an interim service manager was present.

Summary of findings

People and their relatives told us they felt the service was safe but that there were issues with missed and late calls. Comments made included; "[Staff] are wonderful and they are so kind. I feel safe when they are here – when they actually do turn up," "[Staff] make me feel safe in my own home again" and "I love the staff when they come. The only thing that worries me really is the fact that sometimes, no staff turn up because there aren't enough and I don't want to be left alone for a long time in case something happens to me."

People were not protected from abuse as the service did not always follow adequate safeguarding procedures or make appropriate referrals and notifications to relevant bodies. Care records contained information regarding people's needs but information was not up-to-date or person-centred. People also told us that, due to staff being rushed, there was little room for personalised care and support to be provided.

Staff had adequate pre-employment checks carried out before they started working for the service. However, staff did not receive regular supervisions or appraisals. Training updates were not provided regularly, with many staff requiring refresher courses.

People we spoke with told us staff did not always wear Personal Protective Equipment when providing care and support.

The service worked within the parameters of the Mental Capacity Act 2005.

The interim service manager did not carry out regular audits and people told us that, when they had made a complaint or contacted the office with a query or concern, this was not always dealt with and a response was not always received.

We found breaches in five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were breaches in; Regulation 9; Person-centred care, Regulation 12; Safe care and treatment, Regulation 13; Safeguarding service users from abuse and improper treatment, Regulation 17; Good governance and Regulation 18; Staffing.

You can see what action we told the provider to take at the back of the full version of the report.

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 always safe.

People were not always protected from avoidable harm and abuse. Risk assessments were carried out to ensure people's safety but these were not reviewed regularly or with appropriate frequency.

The service did not always make appropriate referrals or notifications to relevant bodies, including CQC.

People said that there were times when no staff member arrived for their call or that staff were extremely late.

Is the service effective?

Inadequate

The service was not always effective.

Staff had not received training updates as required and had not received regular supervision or appraisal from their manager.

People confirmed they were asked for their consent before any care, treatment and/or support was provided.

When care and support was provided, people were supported to eat sufficient food and drink to ensure they maintained a well-balanced diet. However, people told us there were times when they had not been given food or a drink for several hours due to missed or late calls.

Is the service caring?

Requires improvement

The service was not always caring.

Staff had developed positive, caring relationships with people who used the service. People said they did not feel listened to by the provider as many had contacted the office and received no response.

The privacy and dignity of people who used the service was respected and people confirmed this was the case.

There was a lack of personalised and person-centred information in care records.

Is the service responsive?

Requires improvement

The service was not always responsive.

Care plans of people who used the service were not always responsive to their needs. People told us they had been involved in the initial assessments for their care and support but that they had not been involved in any reviews since. Care records did not contain details of people's preferences, likes and dislikes.

Summary of findings

Complaints recorded in the complaints file were adequately addressed, investigated and responded to. However, people told us they felt unable to complain or raise concerns as previous experience had proved this to unsuccessful in achieving their desired outcome. People also told us it was difficult, at times, to get in touch with staff at the office as phones were often not answered.

Is the service well-led?

Inadequate

The service was not always well-led.

The service did not promote a person-centred, open, inclusive and empowering culture. People said they felt able to speak with the interim service manager or office staff but that they did not expect to receive a response.

Regular meetings had been planned for staff to discuss service improvement but only one had taken place at the time of inspection. People who used the service told us they were not actively involved in improving the service.

Regular audits were not carried out.

Housing & Care 21 - Sheffield

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was 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. Prior to our inspection, we had received some concerning information about the service provided by Housing & Care 21 – Sheffield. During this inspection, we looked at whether the service had dealt with or were dealing with these concerns effectively.

This inspection took place over three days, on 08 September 2015 and 01 & 02 October 2015. The inspection was announced on 08 September and 02 October 2015 which meant we gave the provider notice that we were going to carry out the inspection. The service did not know we would be inspecting on 01 October 2015, as this was unannounced. We carried out visits to people in their own homes on 09 September 2015 and spoke with people via telephone over three days. The inspection was carried out by four adult social care inspectors and an adult social care inspection manager over the three days of inspection and two experts-by-experience (ExE). An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We asked the provider to ensure people who used the service were aware they may receive a call from us to talk about the service. On the day of our inspection, we were advised by the interim service manager that everyone who used the service was aware of this. However, both experts-by-experience reported that there were several times where they had contacted people and they were unaware that they may have been receiving a telephone call. We contacted the provider the day after our inspection, when we had received this feedback. We spoke with 23 people who used the service and seven of their relatives, most of which were still unaware that they may have been receiving a call from CQC. Prior to our inspection, we spoke with the local authority care services team and the local authority safeguarding team.

We looked at documents kept by the service including the care records of ten people who used the service and the personnel records of five staff members. We visited three people in their own homes to talk to people, carry out observations and review records stored there. We spoke with the interim service manager, a service manager from another region, the Head of Homecare for the provider, four office staff including care co-ordinators and four care assistants. We looked at records relating to the management and monitoring of the service, including any audits carried out and reviews of care documents and policies, as well as contract monitoring reports from the local authority.

Inadequate

Is the service safe?

Our findings

People told us they felt the service was safe. One person told us; "My carer helps me with a wash and getting dressed and up in the morning. I always feel safe knowing that she is there to help me as I could not manage on my own."

People told us that there were issues with staffing levels at the service, with many people having experienced missed or late calls. One person told us; "Carers can be very hit and miss. I have used the agency for a few months now and have four carers a day. I don't seem to have regular carers. They usually try their best to arrive on time but it can get really frustrating when they are running very late and nobody contacts me. Last week my evening call to put me to bed had not arrived by 10pm. I phoned both the office number and the out of hour's number but no one answered either until well after midnight. When I eventually got through to the emergency number they told me they would get someone out to me but they did not arrive until 3:30am. This has now happened twice. I live on my own and have no family nearby who can help. It was very frustrating and frightening not knowing what else I could do." Other comments made by people included; "I get everything ready and unlock my front door at 8am, which is the earliest that [staff] should arrive. Ideally I would like [staff] to be [at the person's home] about 9am, but most days it can be nearly 11am before I see someone," "Of late, carers seem to have been coming from some towns quite some distance away because they're having to find their way around Sheffield from client to client. I never know really what time they will come either. Last week my lunch was made for me at 3:30pm instead of 12pm. This wasn't the first time this had happened and I was really hungry by the time my meal was made for me later that afternoon," "I have the odd one or two [staff] that come regularly but it's mainly random people," "[Staff] don't always come. For instance, a few days ago they didn't come at all. I was 18 hours without a carer and they are supposed to come three times a day. I get concerned about getting my commode emptied – it's not nice having it sat there" and "[Staff] are not always on time and there have been occasions when they haven't come at all and not even let me know."

We asked people who used the service whether staff stayed for the correct amount of time. Most people said staff did not stay the required length of time. Comments made included; "[Staff] are supposed to be here 15 minutes but they never stop that long. They write in the book [call log] but don't always put the correct time down," "I get a 15 minute call and [staff] are not usually here above five minutes," "I'm supposed to have a call in the morning and a call in the evening but they get done on and off. [Staff] will put in the notes that they have stayed and had a chat but they don't. On one occasion [the staff member] came at 11:55pm – it's just ridiculous" and "[Staff] will stay as little time as possible – they're rushing. The time recorded [in call logs] doesn't always reflect real time."

We looked at information in call logs and held on a spreadsheet of planned vs. actual calls. This spreadsheet compared the planned care and support hours against actual care and support hours provided. We found calls did not take place at planned times and that staff did not always stay the required (planned) amount of time. For example, we found that, over a two week period, one person had received their call over 30 minutes late on nine occasions. Over the same two week period, we found staff had not stayed at the persons home for the required length of time on 21 occasions. A different person, over a different two week period had received their call over 30 minutes late on five occasions and staff did not stay the required length of time on 29 occasions. This information also demonstrated that call monitoring systems that were in place were not always effective in identifying missed calls, late calls or minutes spent at each call.

We looked at staffing levels at the service and found there were not adequate numbers of staff to cover each call and meet people's needs. Many people we spoke with told us there were times when care staff had not turned up to calls or arrived extremely late. We spoke with the interim service manager, who told us there was a recruitment drive currently underway to employ more staff. The interim service manager sent us a 'recruitment tracker', which contained details of all newly employed staff at the service and at what stage in their employment they were. The recruitment tracker demonstrated new staff members had recently started working at the service but some were awaiting pre-employment checks and others were awaiting training dates. The service provided approximately 3,000 hours of care and support to people each week and, at the time of our inspection, there were not enough staff employed and working to cover these hours, resulting in a number of agency staff being used. We asked the interim service manager for details of how many agency staff were

used and how these staff were deployed. However, they were unable to provide an accurate figure and gave varying responses, ranging from three to 15 agency staff being used. This meant the service did not clearly demonstrate their understanding of staffing gaps and the level of agency staff required.

This demonstrates a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they had their medicines administered to them in a way they wanted. However, people told us that there were issues in this area, as there had been many occasions when staff had not arrived for their call or had arrived late. This meant medicines had been missed or given later than required. One person told us; "The timing isn't good, in fact, it's very poor. My daughter was away for a week and [staff] didn't turn up or were late on a few occasions. I am supposed to have my medication four-hourly, otherwise the pain comes. I can't see so I need help with my medication. I am also supposed to have creams on my legs and stockings but I'm not so bothered about that. I am more concerned about getting the pain killers. It is critical for me."

All care records we looked at contained care plans relating to medicines. Each care plan stated the medicine name, dose and frequency required. We looked at people's MAR charts at the office and when we visited people in their own homes. We found there were some gaps in Medication Administration Records (MAR), where there were missing staff signatures. This demonstrated there were times when medicines were not administered and/or MAR charts were not completed. Medicines care plans had not been recently reviewed. In one care record we looked in, we saw a medicines risk assessment had been carried out in July 2014 and had not reviewed since and in another care record, we found medicines risk assessments had not been carried out since October 2013 and no longer reflected the person's current needs around medicines. We also found that there were times when medicines had not been administered at correct times due to staff either turning up late to calls or not turning up at all. This meant the service did not keep under review people's changing needs in regards to their medicines and did not always administer medicines as instructed on prescriptions from GP's.

Daily notes made by staff members about people were not always maintained or completed after each visit and we identified several times where there were gaps in several different care records. This meant staff were not able to keep up to date with any changes or relevant information to effectively provide care and support.

We looked at the care records of 10 people who used the service and found all records contained relevant risk assessments. These risk assessments included assessments of mobility and infection prevention and control. We found no evidence in any of the care records looked at that people had been involved in their own assessments. We also found that risk assessments had not been regularly reviewed and updated to ensure that they were still relevant to people's needs. We spoke with the interim service manager about this, who told us that they were auditing files to see which ones needed updating and that paperwork was currently being updated and new care records being implemented. We looked at the audit of care records the interim service manager had been conducting and saw that, of the 49 files looked at, 43 were out of date and required updating, with some having not been reviewed since 2013. This meant that risks to individuals were not managed and updated in order to keep people safe from abuse and avoidable harm.

People we spoke with told us staff did not always wear Personal Protective Equipment (PPE) such as gloves and aprons, when providing care and support. PPE is worn to protect the staff member and the person who uses a service against the risks associated with the spread of infection and when a staff member is likely to come into contact with infectious materials. Comments made by people included; "Staff put on gloves but we buy them as they don't carry their own," "[Staff] usually wear gloves but not aprons," "[Staff] don't always wear their uniform" and "[Staff] don't always wash their hands or wear gloves when they're handling my [family member's] medicines." This meant the service did not ensure people were protected against the risk of infection.

The above demonstrates a breach of Regulation 12(1)(2a,b,c,g,h&i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the safeguarding log held at the service and found that records kept in the file were maintained, with records being updated with any further developments regarding each concern. However, we found this file did not contain details of all safeguarding concerns and alerts. We spoke with the interim service manager about this, who

Is the service safe?

told us they were unaware of what some of the concerns and alerts were, and that they were awaiting information from the local authority regarding this. We spoke with the local authority, who told us there were an unprecedented number of safeguarding concerns ranging from errors with medicines to unacceptably high volumes of missed calls and that these were currently being dealt with alongside the provider. The local authority confirmed that the provider had been attending safeguarding meetings to address these concerns. We checked information provided to CQC against information held by the local authority and found some discrepancies. The CQC had been notified of 18 safeguarding concerns by peoples' family members, friends, other professionals and the service themselves. However, when we checked this against open safeguarding concerns with the local authority, we found this information did not correspond, with the local authority having 33 current open safeguarding concerns. This demonstrated the service did not always notify CQC of concerns and alerts and did not always take steps to identify where there were issues and concerns around the safe care and treatment of people who used the service.

The above evidence demonstrates a breach of Regulation 13(1)(2)(3)(4a&d) and (6b&d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the safeguarding policy for the service and found it had been reviewed and kept up to date. The policy contained details on how to protect people from abuse and the steps to take, should abuse be suspected. Staff we spoke with were able to explain to us the different types of abuse, the signs to look out for and any actions they would take to report this. This meant policies and procedures were in place and understood by staff on how to protect people from abuse and avoidable harm.

The 'untoward incidents' file kept at the service contained records of incidents relating to people's care and support. Where incidents were recorded, the provider had contacted the Assessment and Care Management team or social workers so they were able to assess the person's needs to identify whether a change was needed to the persons care package. Untoward incident forms were completed, signed and dated by a manager once addressed. This meant untoward incidents were managed.

The 'incident reporting form' file kept at the service contained records of incidents that the local authority had concerns about, including missed calls and safeguarding concerns. The 'incident reporting form' file contained an action plan, demonstrating actions required and being taken to address each issue or concern. We spoke with the interim service manager about this file, who told us that they received this information from the local authority but that they were unsure which person or concern some of the form related to. The provider told us they had requested this information from the local authority but that they had not yet received it. This meant the service addressed incidents and concerns, and kept a log of these.

We looked at the staff personnel files of five staff members who worked for the service and found that adequate pre-employment checks had been carried out by the registered provider. These checks included photographic identification, proof of address and right to work in the United Kingdom, (at least) two reference checks from previous employers to confirm their satisfactory conduct and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups, by disclosing information about any previous convictions a person may have. This meant the service followed safe recruitment practices to ensure only suitable and appropriate staff members were employed.

Inadequate

Is the service effective?

Our findings

People told us they received their care in a way they wanted and were given choices about their care and support, including the food they ate and the clothes they wore. Comments made by people included; "My carer always makes my breakfast for me. She will always ask me what it is I fancy as it can change from day to day depending on how I am feeling. She always makes sure I have everything in front of me and that I'm able to manage for myself" and "My carer only undertakes household chores but as far as I'm concerned she knows what she's doing and I can leave her to get on with it. I have explained to her the way I like certain jobs to be done and she's made no bother about doing it this way ever since." One person told us; "[Staff] always ask me before they [provide care and support]. They ask if it's ok to do that and how I want things doing."

People told us they were usually supported to eat and drink sufficient amounts but that there were times, due to missed or late calls, that people were not supported to eat at an acceptable time for them. One person told us they felt staff needed more training and told us; "My carers make my meals for me. It should be fairly straightforward to as I only have porridge for breakfast but one carer gave me dry oats and was surprised when I said it needed milk adding and in the microwave to heat it up! Someone else was preparing my lunch which was a steak pie and peas. They heated the steak pie but just put the peas cold straight onto the plate. Not very pleasant. I wish they all just had a basic training in how to prepare the necessities. It's not as if I ask them to cook me a Cordon Bleu meal."

We checked staff personnel files and the 'recruitment tracker' that the provider had sent us to see if staff had received adequate induction at the beginning of their employment and ongoing training. All staff had received induction before starting their employment with the service. Induction training covered mandatory areas including safeguarding, infection control, Mental Capacity Act 2005 (MCA) and moving and handling. We spoke with the 'Head of Homecare' and the interim service manager, who told us that staff were not up to date with all their training needs, including refresher training. We asked for a training matrix and the Head of Homecare told us that this was not up to date. This meant the service did not ensure staff were up to date with their training requirements.

Supervisions are meetings between a manager and staff member to discuss any areas for improvement, concerns or training requirements. Appraisals are meetings between a manager and staff member to discuss the next year's goals and objectives. These are important in order to ensure staff are supported in their roles. In staff files we looked at, we found supervisions were not carried out on a regular basis. For example, one staff personnel file we looked at contained records of supervisions having taken place in October 2014, December 2014 and January 2015 but none since. In another staff personnel file, we found only one record of supervision having taken place in June 2013. We asked the Head of Homecare for the supervision matrix. We were not provided with this document. The Head of Homecare told us that this was not up to date and that staff had not received regular supervision or appraisal. We spoke with the interim service manager about this, who told us they were implementing a plan to ensure staff received adequate and regular supervisions and appraisals but that this was not currently underway. This meant the service did not adequately support staff to carry out their roles and responsibilities.

The above evidence demonstrates a breach of Regulation 18(1)(2)(a,b&c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the service to be acting within the Mental Capacity Act 2005 (MCA) legislation. In care records we looked at, we saw that people had signed the 'terms and conditions' of the service, demonstrating people had consented to receiving care and support from Housing & Care 21 – Sheffield. Where people were unable to sign to give their consent, documents were signed by an advocate on their behalf. People told us they were asked for consent before any care and support was provided by staff. Staff we spoke with were able to describe the main principles behind the MCA 2005.

Requires improvement

Is the service caring?

Our findings

We asked people who used the service how they felt about staff. Everyone who received care and support from Housing & Care 21 – Sheffield told us they felt staff were kind, caring and compassionate. Comments included; “My carer helps me to have a wash and get dressed and then prepares my breakfast for me and she is so friendly and nice. It is lovely to see a smiling face each morning,” “All of the carers that I have seen are lovely – they are just let down by the managers and the agency itself” and “My carer when she gets here is lovely and always make's sure that she has all my clothes ready for when we have finished giving me a wash. She always make's sure she tidies up afterwards and I always tell her not to worry as I know she is in a rush but she tries her best to make sure she has time to make me a cup of tea before she goes.”

People we spoke with told us staff took practical action to relieve distress or discomfort. One person told us; “I can get quite cold quickly so my carer always warms up the bathroom with the heater before we go and sort my washing out. This always helps to make sure that my body temperature doesn't drop too much before we can get me dried and dressed.”

Everyone we spoke with told us they felt they had their privacy and dignity respected and that they were treated with respect by staff members. Comments made by people included; “I can’t fault my carers”, “[Staff] look after me well,” “I couldn’t get by without the help of my carer – she is very good” and “[Staff] always knock on my door before coming in – they don’t just walk in uninvited.”

Some people we spoke with told us they felt there were times when staff were rushed so were unable to provide personalised care and support. Comments made included; “The agency can't possibly describe itself as caring. They know I would like to have my shower first thing in the morning as most people do. It's not good enough when carers turn up nearly at midday because I just don't feel like struggling with the shower in the middle of the day,” “My carers seem to know what they are doing most of the time. However, because they can be rushing they sometimes just forget to do the niceties. When they are the only person you're going to be seeing all day, it would be nice just to have a little bit of a chat with them outside of what has to be said in order to get the jobs done. I know it's not their fault because they have so much to do on one shift, but please…,” “The carers that come are fine, I feel sorry for them as they are always rushing about. Some of them walk miles” and “I have developed Parkinson's disease over last few years and I am always conscious that I cannot rush doing things any more. Most of my carers know this but sadly they are always in such a rush to get through their list that they sometimes forget. This can ruin the rest of the day for me as I have to rest and recover.”

People told us they didn’t always feel listened to by the provider. Comments included; “I remember having someone coming to see me from the agency some time ago but since then I have had no contact from any managers. The only people I see are the carers,” “I know who to complain to as it is all contained within my folder but the problem is when you ring up to complain they are never able to do anything about it so you get to the point where you think it's not worth complaining anymore" and “I wasted my time sitting with the manager when I first approached this agency because nothing has been delivered as they said it would. It has been very disappointing, and if I could manage without carers I jolly well would. Sadly though this isn't possible.”

Care records we looked at evidenced that people and/or their relatives had been involved in their care and support planning. We saw care plans contained signatures, evidencing that people agreed to their planned care and support. Each care plan contained details of the persons care and support needs and how they would like to receive this, although these were not always reviewed and updated. We found there was a distinct lack of information to assist with providing personalised and person-centred care and support. For example, we found no information in care records regarding people’s life histories and preferred past times and interests. This meant information to provide personalised and person-centred care was not made available for staff to read.

The above information demonstrates a breach of Regulation 9(1)(a,b&c), (2) and (3)(b&d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service responsive?

Our findings

Most people we spoke with told us they were unaware of how to make a complaint or that they did not feel confident in complaining. Comments made by people included; "I phoned to complain that [family member] was not left a drink in reach and, if I am here [at the person's home], they don't offer one at all. I didn't get far though and certainly no feedback," "I have complained in the past but you just get fobbed off and there is no point" and "I complained about the way one of the staff spoke to [family member] but Housing [and Care 21 – Sheffield] never got back to me."

People we spoke with told us that, although they had been involved in the planning of their care and support, they did not feel that this was always delivered. Comments made included; "It seems a long time ago when I started having care from this agency. At the beginning they promised they could deliver the care I needed and in fact did that. However for the last year or so it has been like having care provided from a completely different agency, as staff have disappeared, appointments have been missed and no one seems to be in charge of trying to sort the problems out" and "I think they are so desperate to get as many clients as they can that they will promise anything when they first meet you but then in my experience, they do not deliver on their promises once you have signed the dotted line." One person told us they had expressed a preference to only have female carers but that this had not been met by the provider. They said; "They come from an agency sometimes. They usually say who they are but I do feel a bit uncomfortable particularly with gentlemen." The relative of one person told us; "[Family member] doesn't want men around and has told [the service] but even last night, a man came so [family member] sent him away. This has happened before and [family member] has sent [male care staff] away. [Family member] isn't happy to have people here [they] don't know late at night, particularly men."

People who used the service told us there were no regular reviews of their care and support carried out. One person said; "I've been with the agency for over two years now and I didn't even know I could request a review, let alone that they should be proactive in organising one every so often." Another person told us; "One of the manager's came the other day and emptied the folder (care record) and put new sheets in but it wasn't really a review."

Everyone we spoke with told us they did not feel that staff had adequate time to provide them with a person-centred service.

We asked people if they had received any surveys or questionnaires from the service for feedback regarding the care and support provided. We saw evidence of some surveys having been recently sent out to people but feedback did not reflect this. People we spoke with told us they had received surveys or questionnaires in the past but none of late. One person said; "A survey or questionnaire? If they had have sent me any of these I would have told them what I thought by now." Another person told us; "I've been sent a survey twice but there was no pre-paid envelope to return it to them. They expected me to put a stamp on my own envelope and I am a pensioner with limited income and I didn't see why I should be expected to pay for an expensive stamp when I already pay for a very expensive service."

The above evidence demonstrates a breach of Regulation 9(1)(a,b&c) and (3)(b,d,f,g&h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the complaints file held at the service and found each complaint had been logged on a concern form. Each form contained details of the complaint, the action taken and the outcome of any investigations. Each form was signed and dated by the interim service manager, once the complaint had been resolved. The interim service manager told us they had recently implemented a form, which was to be completed for every telephone call taken at the office base. These forms asked for details of the call. The interim service manager told us she addressed all complaints and concerns that were recorded on these forms to ensure that people were happy with the outcome. Due to feedback we received from people, during our next inspection, we will speak with people again to see if improvements have been made in this area.

Inadequate

Is the service well-led?

Our findings

People told us they felt the service was not managed well. One person told us; "If you need to phone in an emergency after the office phone has been switched over it is virtually impossible to reach someone to talk to without having to be on the phone for ages or constantly having to redial. Twice now my night time call to put me to bed has not arrived before 10pm and when I have tried to phone it has taken me till well after midnight to get somebody to talk to me and then another two to three hours before someone has come to put me to bed. I cannot do anything for myself and it was very frightening on both occasions to be left so long sitting in my chair." Another person said; "It's really badly organised. I feel sorry for the staff because their rotas aren't done so their calls are in the same area – they're travelling across Sheffield for each call, which wastes time." Other people gave similar feedback, including one person who told us; "I have a morning call which of late hasn't been on time but here is what is so silly. My friend a few doors down also has a morning call. So her carer may see to her then walk past my door to go right across the city to another call. My carer has been over that side of the city then has to come over to me. I have even known it if mine is off that the other girl who sees to my friend has to come all the way back to see to me. It just isn't organised" and another who said; "When I phoned the office nobody has ever called me back. It can be very frustrating. The agency have had some really good staff working for them but unfortunately most of them have left because they have told me they don't feel they get any support whatsoever from their managers. They show me their rota and it seems barmy that they are sent halfway across the town to see one client, and then sent back to see the next. They told me they wanted to help draft the rota themselves as they know their clients and knew the areas where they live but they told me that their managers had said it wasn't their concern."

Other comments made by people included; "I've used the agency for a long time and I remember some months ago a new lady started in the office from what I can remember. Things did start to improve in relation to phones being answered and carers were given the phones so that they could log in when they arrived and left each client. However I understand after about three months she left and things returned to how they had been previously, unfortunately" and "If I'd have run my business the way this company runs the agency I do believe I would have been bankrupt years ago. I just don't understand how they can get things so wrong. I just hope they can sort things out quickly."

Feedback from people demonstrated to us that they were not actively involved in developing the service. One person told us; "I'd have lots of suggestions of how [the provider] could do things better but no one ever asks what can make it better for me." People also told us they did not feel the service enabled or encouraged open and transparent communication. One person commented; "It's quite difficult at times. I'm not sure what's happening with [the service]. I don't get told if [a staff member] is going to be late. They just don't bother getting in touch or just 'skim over it'."

Staff we spoke with told us they felt the interim service manager was approachable and that they were making positive changes to the service. One staff member said; "Since [the interim service manager] has come in, there have been a lot of changes to make [the service] better. A lot of staff don't like [the changes] but it's to make [the service] better."

It is a condition of registration with the Care Quality Commission that the service has a registered manager 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 2008 and associated regulations about how the service is run. The person who managed the service daily was not the person who was registered with CQC as the 'registered manager' but an interim service manager was present.

We looked at the minutes of staff meetings that took place and saw that one meeting had taken place on 07 September 2015 and that meetings were planned weekly for all office staff, including care co-ordinators, who organised staffing rotas, although there was no evidence of these meetings having taken place previously. We saw that, during this meeting discussions were held about how to make improvements at the service. Staff we spoke with said there had been improvements at the service and that they now felt more involved. This demonstrated staff were involved in service improvement.

Inadequate

Is the service well-led?

We asked the interim service manager for records of any audits carried out at the service. The interim service manager told us they had recently been carrying out an audit of all care records to identify areas that required attention. We saw evidence of this and found that the interim service manager had recently carried out checks of 49 care records so far and that required actions were recorded on a spreadsheet. This spreadsheet demonstrated that 43 of the 49 care records checked required updates. We asked for any other audits carried out. The interim service manager told us there were currently no other audits carried out at the service and no quality assurance checks.

The above evidences a breach of Regulation 17(1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the results from the latest surveys that had been sent out. People had made comments on these surveys regarding the lack of continuity of care, too many different staff members, inadequate communication from the office and not feeling listened to. Some people told us they had not recently received a survey. Other comments made by people were positive. One person wrote; “Things seem to be improving” and others commented that they felt care staff that provided care were very respectful and kind.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 9 HSCA (RA) Regulations 2014 Person-centred care 9.—(1) The care and treatment of service users must— (a)be appropriate, (b)meet their needs, and (c)reflect their preferences. (2) But paragraph (1) does not apply to the extent that the provision of care or treatment would result in a breach of regulation 11. (3) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (a)carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user; (b)designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met; (c)enabling and supporting relevant persons to understand the care or treatment choices available to the service user and to discuss, with a competent health care professional or other competent person, the balance of risks and benefits involved in any particular course of treatment; (d)enabling and supporting relevant persons to make, or participate in making, decisions relating to the service user's care or treatment to the maximum extent possible; (e)providing opportunities for relevant persons to manage the service user's care or treatment; (f)involving relevant persons in decisions relating to the way in which the regulated activity is carried on in so far as it relates to the service user's care or treatment;

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12.—(1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (a)assessing the risks to the health and safety of service users of receiving the care or treatment; (b)doing all that is reasonably practicable to mitigate any such risks; (c)ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; (d)ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way; (g)providing relevant persons with the information they would reasonably need for the purposes of sub-paragraphs (c) to (f); (h)making reasonable adjustments to enable the service user to receive their care or treatment; (i)where meeting a service user's nutritional and hydration needs, having regard to the service user's well-being. (4) Paragraphs (1) and (3) apply subject to paragraphs (5) and (6). (5) If the service user is 16 or over and lacks capacity in relation to a matter to which this regulation applies, paragraphs (1) to (3) are subject to any duty on the registered person under the 2005 Act in relation to that matter. (6) But if Part 4 or 4A of the 1983 Act applies to a service user, care and treatment must be provided in accordance with the provisions of that Act.

This section is primarily information for the provider

Action we have told the provider to take

(e)ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;

(f)where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs;

(g)the proper and safe management of medicines;

(h)assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;

(i)where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13.—(1) Service users must be protected from abuse and improper treatment in accordance with this regulation. (2) Systems and processes must be established and operated effectively to prevent abuse of service users. (3) Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. (4) Care or treatment for service users must not be provided in a way that— (a)includes discrimination against a service user on grounds of any protected characteristic (as defined in section 4 of the Equality Act 2010) of the service user, (b)includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint, (c)is degrading for the service user, or (d)significantly disregards the needs of the service user for care or treatment. (5) A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. (6) For the purposes of this regulation— "abuse" means— (a)any behaviour towards a service user that is an offence under the Sexual Offences Act 2003(1), (b)ill-treatment (whether of a physical or psychological nature) of a service user, (c)theft, misuse or misappropriation of money or property belonging to a service user, or (d)neglect of a service user.

This section is primarily information for the provider

Enforcement actions

(7) For the purposes of this regulation, a person controls or restrains a service user if that person—

(a)uses, or threatens to use, force to secure the doing of an act which the service user resists, or

(b)restricts the service user's liberty of movement, whether or not the service user resists,

including by use of physical, mechanical or chemical means.

The enforcement action we took:
Warning notice issued.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18.—(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. (2) Persons employed by the service provider in the provision of a regulated activity must— (a)receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,. (b)be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and. (c)where such persons are health care professionals, social workers or other professionals registered with a health care or social care regulator, be enabled to provide evidence to the regulator in question demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition of their ability to practise or a requirement of their role.

The enforcement action we took:
Warning notice issued.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Personal care

Regulation 17 HSCA (RA) Regulations 2014 Good governance

17.—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—

(a)assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

(b)assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

(c)maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

(d)maintain securely such other records as are necessary to be kept in relation to—

(i)persons employed in the carrying on of the regulated activity, and

(ii)the management of the regulated activity;

(e)seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;

(f)evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

(3) The registered person must send to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request—

(a)a written report setting out how, and the extent to which, in the opinion of the registered person, the requirements of paragraph (2)(a) and (b) are being complied with, and

This section is primarily information for the provider

Enforcement actions

(b)any plans that the registered person has for improving the standard of the services provided to service users with a view to ensuring their health and welfare.

The enforcement action we took:
Warning notice issued.