Care at Home Services (South East) Limited

Care at Home Services (South East) Ltd - Eastbourne

Inspection report

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Ratings

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

Overall summary

This inspection took place between 4 and 25 January 2016. The inspection involved visits to the agency's office and telephone conversations with people, their relatives and staff, between the beginning and end dates. The agency was given three days' notice of the inspection. The agency provided approximately 130 people with a domiciliary service. Most people were older people or people who lived with long-term medical conditions. People received a range of different support in their own homes. Some people received infrequent visits, for example weekly support to enable them to have a bath. Other people needed more frequent visits, including daily visits, and visits several times a day, to support them with their personal care. This could include use of aids to support their mobility. Some people needed support with medicines and meal preparation. Some people needed visits from two care workers to support them with their personal care.

Summary of findings

Care at Home – Eastbourne, supplied a service to people in the town of Eastbourne, and rural areas around the town. The provider was Care at Home Services (South East) Limited who provided domiciliary care services to people from different offices in the South East of England.

Care at Home – Eastbourne had a registered manager in post on the first day of the inspection, 4 January 2016, however this person had completed their application to de-register by the second day of the inspection, 25 January 2016. An application has been made to the CQC for the registration of a new manager. 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 service was last inspected on 6 August 2014. At that inspection we found the provider was not ensuring people were protected against the risks of receiving care which was inappropriate or unsafe because the agency was not planning and delivering care in such a way as to meet people's individual needs. The provider sent us an action plan in which they stated they would have addressed the areas by 31 October 2014. This action plan date to improve risk management has not been met at the time of this latest inspection.

The provider had not identified that it had not met a range of issues from the previous inspection.

These included people and care workers' concerns about visit times, and high numbers of different care workers sent to people. Complaints and concerns raised by people were not reviewed to enable review of the quality of service provision.

The provider had not identified that some people's care plans were not accurate in all areas and did not ensure all relevant risks were identified. Where risks were documented, some people's care plans did not state actions to reduce risk. Some relevant information about meeting people's individual needs was not available in people's homes.

The provider had not identified they were not always ensuring confidentiality of people's information when emailing information.

Some staff had been identified as needing additional support, including during recruitment. Action plans had not been put in place to ensure risks to people were reduced and staff appropriately supported and monitored.

The provider did not have full systems to ensure the safety of people when supporting them with taking medicines. Some records were unclear or relevant information was not available to care workers in people's homes.

The provider and registered manager were not using an effective system to ensure they were aware of all the shortfalls in the service and care and taking appropriate action to make improvements. The provider and registered manager were not following the systems and procedures in practice that they had told us they were using in their provider information return.

Some people and staff reported systems for the induction of new care workers was not effective. This had been identified by the provider and new systems were being developed. There were systems for training and supporting permanent care workers in meeting people's care needs.

Staff had been trained in safeguarding people who could be at risk of abuse and knew what to do to appropriately support people. There were processes to ensure staff were trained in their responsibilities under the Mental Capacity Act (2005).

People said staff knew what to do if they became unwell. People and staff said there were no issues about missed calls due to staff shortages. Where people needed support with their meals, the agency had systems to ensure people's individual needs were met.

Staff spoken with showed a kindly and approachable attitude towards people. Care plans included people's individual past histories.

During the inspection we found five 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 the report.

Summary of findings

The overall rating for this provider is 'Inadequate'. This means that it 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.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

CQC are taking enforcement action to ensure that Care at Home Services (South East) Limited

provide safe and effective care.

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's risk assessments did not identify all relevant areas of risk or actions to be taken to reduce risk.

Where staff needed additional support to ensure people's safety, action plans had not been put in place.

Systems for medicines management did not ensure staff had all relevant information they needed about prescribed medicines.

Staff were aware of how to safeguard people from risk of abuse.

People and staff said staffing levels were satisfactory.

Is the service effective?

Requires improvement

The service was not always effective.

Current systems for supporting newly employed staff were not always effective. The provider had identified this as an area for action.

Training was provided in key areas, including the Mental Capacity Act (2005), and staff received supervision and spot checks.

Staff were fully aware of how to support people in an emergency and if they showed changes in their medical conditions.

Where people's packages included support with meals, there were systems in place to ensure people received the support they needed.

Is the service caring?

Requires improvement

The service was not always caring.

Some people felt some staff were not caring in their approach and were concerned about confidentiality when reporting such matters.

The provider's systems for ensuring confidentiality of personal information were not always effective.

People were complimentary about the caring nature of most staff.

Staff we spoke with showed a caring approach to people and were supported by care plans which included profiles of people's circumstances and past lives.

Is the service responsive?

Inadequate

The service was not always responsive.

Summary of findings

People continued to report they were not responded to in the way they wanted, particularly in the timing of their visits, continuity of care workers and staff doing what they said they needed.

Some people's care plans were not clear and did not outline how care workers were to meet their individual needs.

Some people's concerns and complaints were not reviewed, so managers were not able to take action to respond to people's concerns.

Is the service well-led?

Inadequate

The service was not always well led.

Several areas identified at previous inspections had not been addressed, as stated they would be in the provider's action plan. The provider had also not identified all relevant areas for action in their audits.

Both people and staff gave mixed responses about if the service was well-led.

Some staff commented that office staff were less helpful, others commented on the friendly and supportive approach from the agency.

Care at Home Services (South East) Ltd - Eastbourne

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 between 4 and 25 January 2016. The inspection involved visits to the agency's office on 4 and 25 January 2016. Between these dates, we spoke with people, their relatives and care workers on the phone. We also met with care workers at the office on 25 January 2016. The provider was given three days' notice because the location provides a domiciliary care service. The inspection was undertaken by an inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the agency, including previous inspection reports. We reviewed the provider's information return (PIR). We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We spoke with 15 people who received a service and four of their relatives. We spoke with 13 members of staff, the branch manager and two senior managers for the provider.

During the inspection we looked at nine people's records and nine staff recruitment, supervision and spot check records. We also looked at training records, quality audits and policies and procedures.

Inadequate

Is the service safe?

Our findings

We received mixed comments from people about if they felt safe with the service provided by the agency. One person told us they did not always feel safe because of the different care workers sent to them. They told us "I get a lot of people I don't know," another person said "It is a worry when you don't know who is coming." This was not echoed by everyone. One person told us they felt safe and "I would recommend them, they have been very good to me."

In their PIR the provider stated 'Every service user has a thorough Risk Assessment of the individual themselves and the areas where support and care is provided.' Although the agency had these systems for identifying risk to people and staff, these were not always effective in practice. One person's file showed they had a history of pressure sores, with 12 reports of pressure sores in their daily records in October 2015. The person did not have a pressure damage risk assessment on file. The person's care plan dated 6 February 2015 only documented the use of creams to the affected area with no other information about how care workers were to support the person with reducing their risk of pressure sores. Another person had a body map which documented different areas of pressure damage. None of the records were dated to show when the sores had occurred to enable an assessment of the person's changing risk. This person also did not have a care plan about how their risk of pressure damage was to be reduced.

The provider had also not ensured care workers knew how to reduce risk of pressure damage to people. Of the 13 care workers we spoke with, five were unsure of how to reduce risk of pressure damage. Pressure damage can quickly lead to pressure sores, which can seriously affect a person's health and well-being. The provider had not taken steps to ensure people's safety by ensuring people were adequately assessed for their risk and staff had relevant knowledge, including clear care plans, on how to reduce this risk.

The provider was not ensuring they took appropriate steps when people had other risks. One of the people's files showed they had a record of falling, including two reports of them falling during December 2015. The person's daily records noted the effect of the falls on them. The person's falls risk assessment of 26 March 2015 had not been updated following these falls. Additionally, there were records of occasions when the person had felt unwell and unsteady during December 2015. The branch manager told us of specific reasons why the person may be falling and feeling unsteady. This was not documented. The person's records showed they received care from at least 14 different care workers during December 2015. As the reasons reported by the branch manager were not documented, there was not sufficient information on file to ensure care workers unfamiliar with the person would know how to support them and reduce risk to them of falling.

The provider did not have effective systems to ensure they were assessing the risks to the health and safety of people and doing all they could to mitigate such risks. They were also not ensuring care workers had the qualifications, competence, skills and experience to care for people in a safe way. This is a breach of Breach Regulation 12 of the HSCA Regulations 2014.

The provider did take action to reduce risk to people in other areas. On the first day of the inspection, we identified care workers were assisting a person to move using a type of hoist. There was no information on the person's file about when the hoist had been serviced, to ensure it was safe for the person and care workers to use. By the second day of the inspection, this information was available. The agency was also in the process of ensuring such information was available on all people's files where similar equipment was used.

Several people commented on the quality of some staff who were sent to care for them. One person told us "They keep sending us beginners, when they don't know what they are doing it's a bit much." Another person described a member of staff whose attitude and appearance concerned them because they felt they were not suited to providing people with care.

Following such comments, we looked at staff files to review recruitment and staff support and management systems. We found they did not always ensure the safety of people. One care worker's file showed issues had been raised about their unsafe moving and handling of people during a supervision with them in September 2014. The agency's disciplinary procedure cited an example of gross misconduct as being a "breach of health and safety rules…that may cause serious injury.' Despite this, the care worker's file did not state the registered manager's reasons for not following the agency's disciplinary procedure in this instance. The care worker's file also did not state how this potential risk to people was to be followed up to ensure the care worker was safe to support people who had mobility

difficulties. Additionally the care worker's file did not include any supervision or 'spot check' information about their safety in moving people after the 2014 incident. Such matters were also not documented as an area for consideration in their annual appraisal.

This was not the only case where relevant matters were not followed up. Five of the nine staff recruitment files we looked at related to care workers where it was documented at interview that they had not done care work previously. For three of these five staff, their English language skills were also identified as an issue. For example one of these care worker's file documented 'Language barrier.' Although the branch manager reported they performed an English language literacy test, only one of the three care workers had such a test on file. None of the care workers' files had a written action plan to outline how the matters identified at interview were to be addressed. All of these care workers were working on their own with people, but there were no records of a supervision or 'spot check' on their files to show they had been assessed as safe to do this. A newly employed care worker confirmed they had not had supervision or a 'spot check' since they started working for the agency and this concerned them because they had not worked in care in their previous role. The branch manager showed us a telephone interview which had taken place with one of these care workers, three months after they started. Notes of this conversation stated the care worker "Had made great progress." The branch manager confirmed this statement was as a result of the phone conversation, not as a result of any observation of the care worker's practice. Where issues and potential risk had been identified about staff, the provider had not taken action to ensure they could confirm that care workers who worked on their own with people, were safe to perform their role.

The provider was not ensuring that there were sufficient numbers of suitably qualified, competent, skilled and experienced care workers employed to provide care to people. They also did not ensure that care workers received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out their duties. This is a breach of Regulation 18 of the HSCA Regulations 2014.

The provider had taken action in other areas. The CQC had recently inspected other agencies belonging to Care at Home Services (South East) Limited. Following this they had had set up a system to audit all staff records to ensure they included all relevant documents to provide evidence staff were safe to work with people. All staff files had been audited and matters which needed to be addressed had been identified for action.

In their PIR, the provider stated 'There are strict procedures for assisting with medication.' The provider had not ensured all relevant matters had been identified and action taken to ensure the safety of people when supporting them to take their medicines. One person was prescribed a medicine where the dose could vary, depending on blood test results. There was a potential risk to the person's health and well-being if they were supported in taking an incorrect dose of the medicine. The person's care plan dated 6 February 2014 stated their medicines were to be given as per their medicines administration (MAR) chart. The only information about the medicine which was given in a variable dose was 'see book' with no further information, including where the person kept the book. The person's medicines risk assessment had no information about the risks to the person of incorrect dose of the medicine. The person's December 2015 MAR chart was unclear. It had four different instructions about different doses of this medicine. These were hand-written down the side of the chart and under the medicine, three were crossed out, and none were dated so it was not possible to identify when changes had been made or discontinued. The person's daily record had two references to changes in the dose of their medication. The first one did not state what the dose had been changed from and to. We showed this record to the branch manager and asked them about their measures to reduce risk to the person. We were shown the person's computer records which evidenced the agency had tried to clarify the dose the person was to be given. This record was not in the person's home. The person was supported by a range of at least 16 different care workers during December 2015, so the lack of clear information in the person's home could put them at risk of being supported in taking their medicine at the wrong dose.

Several of the people were prescribed skin creams. We asked care workers about instructions about their application and received mixed replies. One care worker told us "Some do some don't" about if people's files included instructions on the application of prescribed skin creams. Another care worker told us they had needed to phone the office at times about instructions for applying people's skin creams. However another care worker told us

Inadequate

Is the service safe?

all the information was available on people's files. We looked in people's care plans and saw the information provided was variable. For example one person's records documented they were prescribed two skin creams but there was no information on which cream was to be applied where. Another person's care file did document the skin cream to be used but did not state where it was to be applied. However another person's care file included full information on their prescribed skin creams and where they were to be applied. The agency's medicines policy dated 30 April 2014 did not include a section on the application of skin creams. We were informed by a manager for the provider that the policy was currently being revised.

The provider was not ensuring the proper and safe management of medicines. This is a breach of Regulation 12 of the HSCA Regulations 2014.

There were safe systems for administration of medicines in other areas. All of the people who were supported with taking their medicines had a MAR which showed they had been supported in taking their medicines. Where people did not take their medicines for any reason, this was fully documented on their MAR, using a coding system. For example one person had asked that care workers pop their tablets out from their dosette during their afternoon visit and to place them by them to take during the evening. This was fully documented in their care plan and their MAR chart was completed using the appropriate code to show this had taken place.

In their PIR, the provider stated staff were aware of the procedures to be followed 'when there is suspicion or evidence that harm or abuse is taking place.' All of the staff we spoke with were aware of the importance of safeguarding people from risk of abuse. They were also aware of a range of factors which could indicate a person was being abused. One care worker told us "I had to raise an issue once about the safety of a client and they [the office] dealt with it." Another care worker said the training they had been given made them "Hugely aware" of the risk of abuse to people, and their role in ensuring people's safety. A care worker told us if a person was upset about something the "Main thing is to calm them down first." They said they were aware that if the person was living with dementia they may have difficulty in explaining what the issues were and they needed to "Be supportive" to the person and then report the actual issue to the office. Another care worker was clear about how to report issues to the local authority safeguarding team if they felt the registered manager had not taken appropriate action to safeguard a person. The agency had clear procedures for identifying and supporting people who were at risk of abuse. They had made referrals to the local authority safeguarding team in the past, in support of people who might have been at risk of being abused.

None of the people we spoke with reported they had ever experienced a call being missed through staff shortage. Care workers confirmed this to be the case. The branch manager told us they had a clear system for investigating any reports of missed calls for people, so they could ensure this was not taking place.

Requires improvement

Is the service effective?

Our findings

We received mixed comments about whether care workers could effectively meet people's needs. One person told us "They seem to send us all the new ones and I have to run round and show them what to do and I'm supposed to be resting because of my hip." A person's relative told us "They keep sending us beginners, if they have been here a week, then they are on their own." This was not echoed by other people. One person told us "They seem well trained, you get one or two of course." Another person told us "If there is someone new they come with someone first until they know the ropes." Another person told us ""They know what they are doing and seem well trained."

We also received mixed responses from care workers about training. One newly employed care worker told us they had shadowed experienced care workers after their induction for three to four days, but this didn't prepare them in the way they needed. They said for example they had no training in how to care for people who had catheters, although they had been sent to people who needed support with them. Another new member of staff who had not worked in care before said they were concerned about caring for one person who had mental health needs. They said as they had not been trained about such people's needs they felt they were did not understand how to meet their needs, which could vary. However a newly employed care worker described their induction at the provider's training department as a "Good induction."

In their PIR the provider said they were currently introducing on-going training for new staff, this would 'ensure that our approach both conforms to legislation and is workable within our organisation.' A senior manager for the provider said this new induction programme would also ensure all newly employed care workers were allocated to a mentor and received regular supervision and 'spot checks' through their induction period. This new system as described in the PIR was not in full use at the time of this inspection.

Staff commented positively about on-going training. One care worker told us "We have lots of training, more than I've had with any other agency." Another care worker told us their training covered "Pretty much everything." A care worker said they had been trained in meeting the needs of people who were living with dementia. They said this training had helped them as they gave care to several people who had such needs. Care workers told us they could request training. A care worker said they had asked for training in dementia and had received it. They had also recently asked for palliative care training and were waiting for a date. A senior manager for the provider was aware of staff requests for training. For example a care worker had asked for training in supporting people who were living with a brain injury and they were trying to source such training. A senior registered manager for the provider said the provider was currently appointing a training manager for the group who would lead on sourcing training to ensure staff could work effectively with people. The provider had training matrix which enabled them to review ongoing training for staff in key areas such as fire safety and safe moving of people. The matrix enabled them to identify areas where staff needed updating in their standard training programme.

We received mixed responses from care workers about supervision, 'spot checks' and appraisals. One long-term care worker told us they didn't have supervision often and their last 'spot check' was "Not recent." A newly employed care worker told us they had started their employment three months ago and had not had any 'spot checks' or supervision. Other staff did not echo this. One care worker felt they were monitored during 'spot checks' regularly to see they were "Doing their job properly." Another care worker reported they could bring up issues at supervision and 'spot checks' and know they would be acted on. A senior manager for the provider reported that as part of changes they were making in staff support there would be more emphasis on staff supervision, 'spot checks' and mentoring systems.

All of the care workers we spoke with said they had been trained in the Mental Capacity Act (MCA)(2005) or had dates for them to attend this training, during the spring. A senior manager for the provider said the provider had set up a programme across the group so all staff could be trained in the MCA during 2015/6.

People said the care workers knew what to do if they were unwell. One person told us they lived with asthma and care workers supported them when they had an attack. A person who lived with asthma had clear information on their file about how to support them if they did have an asthma attack. Care workers were clear on what to do if a person became unwell and needed assistance from external healthcare professionals, including emergency

Requires improvement

Is the service effective?

services. A care worker described an occasion when they had found a person had fallen and they suspected they had sustained a fracture. They had called the emergency services and remained with the person until the ambulance arrived. Another care worker said a key area was to make sure a person was “Comfortable and safe” until the emergency services arrived. We looked at the on-call record. This showed a recent record about when a person had been unwell. The record showed the care worker had phoned the person’s GP for support about their condition.

Some people were supported with their meals. People made positive comments about this. One person said “They have just got me a nice poached egg.” Another person said ”They make me a really nice cup of coffee.” A care worker said where they supported a person with eating, they always asked the person what they wanted and wrote down what the person had asked for, so there was information about this for other care workers. We looked at the records of a person who needed supporting with their meals, they had detailed information in their care plan about their meals and how they wanted them to be prepared. Another person had clear records of the meals they had chosen to eat.

Requires improvement

Is the service caring?

Our findings

We received mixed comments about the caring attitude of care workers. One person told us "They do as little as possible" about the care workers. Another person said "They take the mick out of me." The branch manager said they took all such matters seriously and took action where such matters were brought up with them. Such comments were not echoed by other people. One person said "They are nice, when they are here." Another person said "My regular carer is wonderful and one of the weekend girls is too." Another person told us "They are splendid."

We asked people how they gave feedback to the agency on their opinions about their care workers. One person told us this was "Difficult" because a care worker had always been present when they were visited by a manager. Because of this, they did not feel they could raise issues with managers in confidence. They said there did not appear to be other systems for them to feedback on issues about the service in a confidential way. A person's quality audit completed by the agency documented about a care worker who the person said was "Abrupt" and "Rude." A senior manager for the provider said the provider did not currently perform overall reviews of comments in quality audits. Following our feedback of other agencies owned by Care at Home, the senior manager for the provider said the provider was developing systems to support people in providing confidential feedback in the future. They were currently assessing how this could be done, including working with external charities.

Care workers raised issues with us about confidentiality in other areas. Care workers told us information about who they were visiting was emailed to them. On occasion, due to changes in rotas, for example if care workers went of sick, they could also receive revisions to their rota by email when they were already on duty. This meant they could have several sets of people's confidential information emailed to them in one day. We asked a senior manager for the provider about systems for password protection or encryption of emails to ensure confidentiality of people's information, should another person gain access to information on a care worker's phone. The senior manager for the provider reported such systems were not in place.

The provider did not have appropriate systems to ensure confidentiality of people's information and that people could feedback confidentially on service provision. This is a breach of Regulation 17 of the HSCA Regulations 2014.

Care workers we spoke with were very aware of the importance of ensuring people's confidentiality. A care worker told us "You don't talk about other people." Another care worker said ensuring confidentiality could be complex, for example where they supported several people who were living in the same sheltered accommodation. They said they were always polite when people asked about what was happening with other people. They then changed the subject to something like the weather or what was in the news. Another care worker said they sometimes supported new care workers by shadowing them when they started. They said they always stressed with them the importance of confidentiality.

People said they appreciated the way care workers who were new to them always identified themselves when they first arrived. One person said "They show me ID and everything." Another person said "They introduce themselves when they come in, they are polite and nice."

People said the care workers who visited them regularly were caring towards them and treated them with respect. One person said they liked their regular care worker "Because they are nice, but I would like the same people." Another person said "I would recommend my regular carers." Another person said their regular care worker was "Absolutely marvellous," this was because the care worker "Goes the extra mile. She's what I'd call a real carer." A care worker told us a key area when they were supporting a person was to "Treat someone how you want to be treated yourself."

Managers commented on the caring attitude of care workers during 'spot checks' and supervisions. One care worker's record said the care worker "Has good communication with" the person. Another care worker's record described how the care worker was "Helpful" to people. A different care worker said the care worker had "Excellent rapport with clients."

In their PIR, the provider described their care plans as 'hugely person centered and each person has an 'about me' profile section in the file and in the office. By offering so much information to care staff about the person they are supporting, it ensures that communication between

Requires improvement

Is the service caring?

service users and staff takes account of this history and preferences, and staff can get on with the tasks in hand.' We saw all care plans included a section on the person's past life and preferences. Some of these were detailed, for example describing the person's former working life. One person's care plan documented their first language was not English. The branch manager said the agency were fortunate to have employed two care workers who also spoke that language. They said they ensured this person was visited by these two care workers. This meant the person's individual needs could be met by care workers who could talk with them with ease and also support them in a way so their independence was fostered.

Inadequate

Is the service responsive?

Our findings

We received mixed responses from people about if care workers came on time to support them. These included one person who told us "They have been as much as two hours late and no one rings." Another person said their relative was meant to have their visit at 7:00am to get them ready for a day centre, and the agency knew this. They told us due to their care needs, the person needed an hour's visit to get them ready. They said there had been occasions when care workers were very late and had come a quarter of an hour before the person's booked transport came. Another person said care workers sometimes came early. Their evening visit was meant to be at 9:00pm but sometimes care workers came at 7:00pm which was "Far too early" for them to go to bed. These comments were not echoed by everyone. One person said "They come more or less on time." Another person said "I have three double up calls a day, they are usually on time."

At the previous two inspections, on 4 January 2014 and 6 August 2014, similar issues were identified about inconsistency in the timings of visits. The provider's action plan stated 'Any change of scheduled call time or carer will be communicated by telephone to the clients.' They stated the matter would be addressed by 31 October 2014. Reports from people showed the agency did not consistently follow their action plan. One person told us "They don't ring me if they are very delayed." Another person told us "They change who is coming, or people are late and they never ring you."

We asked care workers about travelling time between visits. Again we received mixed replies. One care worker told us time between calls depended on their rota. Some rotas did not give them enough time between visits. Another care worker told us if rotas were changed due to staff sickness they could be "All over the place," and this affected travelling time. Another care worker said care workers who walked between their visits had enough time but some rotas which depended on driving between visits did not. Another care worker said they always had enough time between their visits.

We asked a senior manager for the provider if they had a system for assessing the incidence of visit times which were significantly later or earlier than anticipated. They gave us their electronic record for two days in January 2016. They had manually highlighted the majority of the late calls for us. This was because they said they did not have an automatic system for identifying significantly late or early calls. When we reviewed this information, it showed 8.5% of the visits for these two days were over half an hour later or earlier than planned for. This included a visit which was documented as planned to start at 9:40am, which actually started at 10:26am, 46 minutes later and another which had been planned to start at 5:30pm which started at 6:21pm, 51minutes later.

People also gave us mixed comments about if the same care worker or group of care workers visited them. This matter had also been identified at previous inspections. Comments included one person who told us "They keep sending new ones and I can't be doing with it, I see one or two regular then I don't." Another person said "Sometimes different people just appear." Another person told us "It's never the same people, it would be much better if it was people that I knew." This was not echoed by other people. One person told us "I know who is coming, I have a rota."

We received mixed comments from care workers about if they regularly saw the same people. One care worker told us they had "No regular clients." Another one told us their rota was "Constantly changed, I have no regular clients." This was not echoed by other care workers. One care worker told us about "80%" of the people they visited were "Regular clients." Another care worker said they "Always" had people they saw regularly.

In their PIR the provider stated 'Where we support people with special needs or dementia, consistency of the care team is vital and we strive to support them with a small team who know them well.' The agency had not identified they did not always do this. We looked at daily records for nine people in December 2015. One person's records showed they had complex medical needs, particularly in relation to support in taking medication. They had been visited by at least 16 different care workers during December 2015. Another person's records documented they had needs relating to a potentially unstable mental health condition. They had been visited by at least 14 different care workers during December 2015. We asked a senior manager for the provider how they assessed how many different care workers were sent to people. They told us they did not currently have a system for doing this.

People gave us mixed comments about their care plans and about how staff responded to their needs. One person told us "They are supposed to take me out for a walk when

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it's dry, to get me used to going out again, but I have only been out three times since July." Another person told us care workers were meant to take them to the shops but this didn't happen "Because they do not have the time." This was not echoed by other people. One person told us "I have a care plan, but the morning carer knows what she is doing and I am sensible, I can tell the evening ones what to do." Another person told us "I have a care plan, I had a say in it and I have had a review."

Care workers also gave us mixed comments about care plans. One care worker told us care plans did not reflect the needs of people they currently visited. However another care worker told us they always visited the same people, so they knew them and "Yes everything's in care plans."

The provider had not ensured they had put in effective systems to ensure issues relating to visit times and number of different care workers people were visited by had been addressed. They were also not ensuring all people received appropriate person-centred care which met their needs and reflected their preferences. This is a breach of Regulation 9 of the HSCA Regulations 2014.

In their PIR the provider stated 'Each Service user has a risk assessment which is kept up to date, and which takes into account what activities they may wish to continue, despite the risks involved.' The provider had not identified they were not always doing this.

We looked at nine people's care plans. They were variable and did not always ensure a care worker who was not familiar with the person would know how to support them. A person had a care plan dated 3 December 2014, which was reviewed on 13 August 2015. This documented the use of two mobility aids to support the person. Care workers told us the person's sight was not good, and they lived in a small, rather cluttered room. Although the person's care file documented they were registered blind and that their room was small, there was no information included in their care plan on how risks to the person and to care workers were to be reduced. A different person had records about a splint, which needed to be put on their ankle. Their notes also documented they were living with memory difficulties. The person did not have a care plan or other information about how the care workers were to support the person with putting on the splint or even which ankle the person needed the splint placing on. Another person's care plan included instructions from an external healthcare professional about how they were to be supported in moving. The person's daily records showed care workers were not following these instructions. The branch manager told us this was because care workers had found the person was not able to follow the external healthcare professional's instructions. They showed us computer records about how they were seeking clarification and review of how care workers were to support the person. As these were not in the person's home, there was a risk care workers who were not familiar with the person would not be supporting the person in a consistent way.

The provider was not ensuring they had systems to ensure care could always be safely provided to people and risks mitigated. This is a breach of Regulation 12 of the HSCA Regulations 2014.

Some care plans were clear and informed care workers of how to meet people's needs. A person had a care plan which stated how care workers were to ensure a person's comfort before they left their home, this included making sure they had the television remote control placed either in or by their hand. Another person needed to be supported to be moved using a ceiling hoist. They had a care plan which directed care workers about what to do, including ensuring the safety of the person while the hoist was being used.

We received mixed comments about if the agency was responsive when people raised issues. Comments included one person who told us "I don't like to say anything to the office," saying they did not find office staff responsive to what they said. Another person told us "It's the office, we had one carer we said we didn't want back and they kept sending them, I rang up but all they said was 'oh well we'll make a note of it.'" They said the matter had not been resolved. Another person told us about a matter which concerned them, they said "I've told the office and it's 'well we'll see what we can do,' and nothing happens." Another person told us if they told the office about their concerns they did not "Really do anything." However another person told us about an issue which they had raised with the office and that action had been taken, saying "I know to say quicker now, but I have had no need to."

We looked at the complaints register. This showed two formal complaints had been raised during 2015. We asked the branch manager how they documented and investigated issues such as those reported to us. They said they were documented on the person's individual computerised file. We asked if they had a system for

Inadequate

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monitoring matters of concern for people, to identify trends and ensure all matters had been investigated and responded to in accordance with the agency's policies. They said they did not currently have such a system. We asked them if they were aware of comments such as those reported to us by people. They said they were not aware of such reports but would have taken action if they had been informed about them.

The provider was not ensuring they had effective and assessable systems for identifying, receiving, recording, handling and responding to complaints by service users and other persons. This is a breach of Regulation 16 of the HSCA Regulations 2014.

We looked at the two formal complaints which had been made to the agency. One had been responded to in detail. For the second formal complaint, a senior manager had written back a polite letter about the issues which had been raised. The branch manager reported these issues were now resolved.

Inadequate

Is the service well-led?

Our findings

We received mixed comments from people about if the agency was well led. Comments included "No I wouldn't recommend them," and a person who said "It's such a muddle." Another person described office management as "Just dozy" and another said "The office don't do anything." Other people were more positive. One person said "I would recommend them, I think," another person said "I would recommend them because they are nice" and another "I would certainly recommend them, no problem."

We also received mixed comments from staff. Comments included "I don't think I'd recommend a friend to work here," that the office staff sometimes had the "Wrong attitude about client care" and another that "Sometimes you phone them up and they don't do anything." Other staff were more positive. One care worker told us "I'm happy to work for them" and another "It's pretty well organised, happy about everything."

At the last two inspections, on 4 January 2014 and 8 August 2014, issues were identified in relation to Regulation 9 of the 2010 Regulations. This was about the planning and delivery of care and meeting individual people's needs. In their action plan after the inspection of 8 August 2014, the provider stated they would address the issues by 31 October 2014. In their PIR the provider stated 'The Operations Director collates information on all branches quality assurance results and analyses them for themes or comments which she needs to address at branch level.' In relation to timings and consistency of visits to people, they stated they had migrated to a new 'software package for rostering care calls, which is far superior and reliable than our previous software, and will enable us to schedule far more effectively, and with much more thought and attention as it tracks continuity of staff and also the best geographical routes.' The provider's processes had not identified and addressed a range of areas and that they had not met breaches from previous inspections.

In their action plan after the last inspection of 8 August 2014, the provider stated rotas would be sent to people weekly on a Thursday, and each coordinator would inform clients daily if there had been any changes made to regular times or carers. The provider had not identified that people continued to report that care workers did not come at the time anticipated, that people continued to receive visits from a wide number of different care workers and were not following their action plan in relation to the issuing of rotas to people. A person told us they had "Asked for a rota, never had one," another "No I don't have a rota, I can't remember seeing one" and another "I have a rota but it's not who comes, different people come." The branch manager showed us they had compiled a list of people who had asked for a rota. This was because other people had asked not to be sent a rota. The provider had not revised their statement of purpose of 14 January 2014 to inform people of how they could obtain a copy of their rota if they wished to change their mind in the future. This matter was not reviewed during annual reviews of people's care to check they were happy with their reported choice not to have a rota sent to them.

We reviewed the provider's quality audits. Several of the quality audits documented people's concerns in relation to late visits, people not wanting to be visited by certain care workers and a lack of action in relation to this. We asked a senior manager for the provider how they collated all such reports from people to ensure their frequency was assessed and relevant action taken where appropriate. They told us they did not have a system for doing this.

Some staff had raised issues of concern, including during supervision. For example one care worker's supervision record documented that they found a particular person "Intimidating." A care worker also told us they had reported about a person's behaviours which they found "Difficult," but the office had "Not done anything." Such comments were not collated or action plans put in place to ensure care workers were appropriately supported in their roles.

The provider was not ensuring its systems identified and were acted on in other areas. Some people's records showed occasions where they had fallen and where people had sustained pressure damage, so we asked the branch manager how they monitored, audited and acted on such information, to ensure people's safety and well-being. The branch manager showed us their monitoring system for people who had sustained pressure damage. The monitoring record for December 2015 documented three people's names. However one of the nine people we reviewed had records of pressure damage in their daily records. Their name was not on the list. Therefore the agency's monitoring system was not accurate. The monitoring record did not state actions taken to ensure the person's safety, apart from if the damage had been reported to the district nurse, with no information on what

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actions the district nurse had requested and how the agency were to ensure it followed the district nurse's directions. It also only stated 'yes' or 'no' to if the person's care plan had been changed, with no assessment of why the care plan had not needed to be changed. This meant the provider was not reviewing if actions taken had been appropriate to ensure people's health and well-being. The branch manager reported they also monitored people's falls in a similar way. We asked for the monitoring record on both the first and second day of the inspection but it could not be found. This was despite one of the nine people we reviewed having reference to two falls during December 2015.

The provider had also not identified that other records were not accurate. A person had a care plan which stated they were 'double amputee.' It did not give any information on which limbs had been amputated or the extent of the amputation. A care worker told us, due to this lack of information, they had not been fully prepared for the person's degree of disability and were concerned they may have offended them, due to this. A person had a record which documented they had 'challenging behaviour." Their care plan had no information on how they exhibited the 'challenging behaviour' or what actions care workers were to take if the person showed these behaviours. A person had a care plan which stated care workers were to 'remove' their used stoma bags. There was no information in the care plan about how these bags were to be safely disposed of, to ensure risk of cross infection was reduced for the person, family members and care workers. The provider's infection control policy dated 15 April 2014 only stated that staff were to 'dispose of all rubbish properly,' with no further information on how this was to be done or the potential risks of different categories of rubbish. This meant care workers did not have relevant information to ensure they were aware of their responsibilities for safe disposal of potentially contaminated items.

The provider did not have effective systems to ensure they assessed, monitored and improved the quality of services and their systems mitigated risk to people. They also did not ensure they maintained accurate records for people. The provider was also not seeking and acting on feedback from people. This is a breach of Regulation 17 of the HSCA Regulations 2014

Staff gave us mixed responses about if they were supported by the agency's management systems. One care worker told us "I flag it up and nothing gets done." Some care workers were quite reluctant to answer even simple questions from us, and their main response was "Everything is alright." However other care workers were far more positive. One care worker told us the agency was "Good enough to work for, no problems." Another care worker told us the managers "Do make time for you." Another care worker told us "It's a good company to work for," describing it as "Supportive." Another care worker described the agency as "Very professional." A care worker told us staff meetings "Are useful" and another care worker reported "We can raise issues."

The agency had a lone working policy and care workers said they felt safe working on their own. Care workers all said there was a supportive on-call system which they could use if they did not feel safe or needed support when they were out on their own.

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 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider was not ensuring they had effective and assessable systems for identifying, receiving, recording, handling and responding to complaints by service users and other persons. This is a breach of Regulation 16(1)(2) of the HSCA Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider was not ensuring people were provided with appropriate person-centred care which met their needs and reflected their preferences. Regulation 9 (a)(b)(c) of the HSCA Regulations 2014.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have effective systems to ensure they were assessing the risks to the health and safety of people and doing all they could to mitigate such risks. They were also not ensuring care workers had the qualifications, competence, skills and experience to care for people in a safe way. The provider was not ensuring the proper and safe management of medicines. This is a breach of Regulation 12 (1)(2)(a)(b)(c)(g) of the HSCA Regulations 2014.

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider was not ensuring that there were sufficient numbers of suitably qualified, competent, skilled and experienced care workers employed to provide care to people. They also did not ensure that care workers received appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out their duties. This is a breach of Regulation 18 (1)(2)(a) of the HSCA Regulations 2014.

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective systems to ensure they assessed, monitored and improved the quality of services and their systems mitigated risk to people. They also did not ensure they maintained accurate records for people. The provider did not have appropriate systems

This section is primarily information for the provider

Enforcement actions

to ensure confidentiality of people's information The provider was also not seeking and acting on feedback from people, particularly in relation to visit times and number of different care workers visiting them. This is a breach of Regulation 17 (1)(2)(a)(b)(c)(e)(f) of the HSCA Regulations 2014

The enforcement action we took:
Warning Notice