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South Western Care Services

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

South Western Care Services in a domiciliary care service that provides support to 60 predominantly older people living in their own homes in the South of Cornwall, from it's office in Helston. The provider also operates a day care centre from the same address and many of the people who use the daycentre are supported at home by the domiciliary care agency.

The inspection took place between the 04 and 06 June 2018 and was announced. This was because we needed to ensure staff would be available in the office during the inspection visit. Not everyone using South Western Care Services receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

The service is not required to have a registered manager as the register provider had direct oversite of the service's performance and is based in the service's office on a full-time basis. The provider was legally responsible for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider was supported by a team of office based managers and staff who had well defined roles and responsibilities.

This was the first time the service had been inspected at its current address following changes to its registration. The service had previously operated from a different address where it was registered as Southwestern Care Services Ltd. We had previously completed a responsive inspection of Southwestern Care Services Ltd in March 2017 and found the service to be good in both key questions inspected. A comprehensive inspection of Southwestern Care Services Ltd had been completed in August 2016 and had found the service to be good over all but requires improvement in relation to our question 'Is the service responsive'.

Prior to this inspection we received information of concern that indicated people's needs were not being met as care visits were not being provided on time and for the full duration. We looked at the concerns raised as part of our inspection.

The service's visit schedules, call monitoring data and people's daily care records confirmed visits were regularly not provided on time or for the correct duration. For example, one person was due to receive an evening visits at 9:30pm. However in one week this visit had only twice been provided within 30 minutes of the planned start time. The earliest visit had started at 8:40pm while staff did not arrive until 10:25pm for the latest visit. Eighteen of the 20 people we spoke with raised concerns about the variability of the timing of care visits, with some people reporting this made them feel unsafe. Comments received from people and their relative's included, "No [I don't feel safe] because I never know when they are coming", don't know when they are coming. I have to wait for them to help me get up and go to the toilet. It can be any time between 7am and 9am and sometimes I am bursting (for the toilet). It's awful, waiting" and "No they are never on time. Sometimes they don't come to put [My relative] to bed until 11.30pm, it's too late, I am

exhausted by then."

Our analysis also found that care visits were regularly shorter than planned. For example, one person who was scheduled to receive 15 hours of support during three weeks was only provided with eight hours and fifteen minutes of care. People confirmed that care visits were regularly shorter than planned and told us, "They are meant to be here for half an hour but I get 20 minutes at most" and "Sometimes I just get about 10 minutes. They have barely got the chance to say hello." Staff said, "I don't think people are always getting the service they are paying for. That is mainly down to staff rushing and not staying for the time they should."

The service operated in a rural area and staff regularly had to travel significant distances between consecutive care visits. The service's visits schedules did not include reasonable amounts of travel time between visits. Staff, were generally allocated five minutes travelling time between each care visit but we found numerous examples where journeys of more than 15 minutes were required between calls. Staff told us, "Travel time means some visits are shorter than they should be but it is only normally tablet (medicines) visit that are short" and "There's not enough travel time, the shortage of travel time has a knock-on effect on the time spent with people providing care."

The service had quality assurance systems in place which included analysis of staff arrival time and visits duration. These systems had identified people were not receiving the care as planned and this issue had been repeatedly raised during staff meetings. However, the provider had failed to take effective action to address and resolve these issues.

People and their relatives told us that they had regularly made complaints about the services performance, but that these complaints had not been appropriately dealt with and resolved. Their comments included, "I spoke to them (Managers) and they said they would try to sort it out but they didn't really, so I didn't ask again", "I have had to draw a few things to their attention but they don't really do anything about it" and "I have mentioned things to carers to give them a chance to buck their ideas up before complaining. That usually does the trick because they won't listen in the office."

There was a system in place to record details of all complaints received by the service. However, these records had not been accurately maintained and during our inspection we identified complaints that had not been formally recorded. In addition, there was a lack of evidence to demonstrate complaints had been investigated and of responses to complainants explaining what action had been taken to prevent similar issues from reoccurring.

The provider had also failed to notify the commission of significant incidents that had occurred and following the inspection four additional notifications were submitted.

The service's recruitment practices were safe and there were enough staff available to meet people's care needs. The service had appropriate induction procedures in place and all staff new to the care sector were supported to complete the care certificate. Staff training had been regularly updated and supervision provided.

Staff supported people to make decision and choices. However, we have recommended that senior staff completed additional training in relation to the Mental Capacity Act 2005 and a new system be introduced to accurately record details for any powers of attorney people had appointed.

Care plans included sufficient information and guidance to ensure people's care needs were met, however

information available to staff on the support people needed with medicines was not always sufficiently detailed. We have recommended the service reviews its systems for supporting people with medicines to ensure they are in line with the recently issued national guidance.

People told us staff did not always wear personal protective equipment during care visits and the service had received a complaint in relation to the inappropriate disposal of used gloves. As a result we have recommended that staff infection control training be refreshed.

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

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The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Care visits were not always provided on time and routinely shorter than planned.

Although personal protective equipment was readily available from the service's offices people reported this was not consistently used during care visits.

Recruitment procedures were safe and staff understood local procedures for the reporting of suspected abuse.

Is the service effective?

Good

The service was effective.

Staff, were well trained and there were appropriate procedures in place for the induction of new members of staff.

People's choices were respected and staff understood the requirements of the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not entirely caring.

People had mixed views on the quality of support they received from care staff.

The service had endeavoured to respect people's preferences in relation to the gender of their care staff.

People were involved in making decisions about how their care was provided and were able to make unwise choices.

Is the service responsive?

Requires Improvement

The service was not responsive.

Complaints had not been appropriately investigated and resolved.

People's care plans provided staff with sufficient detailed information to ensure their needs were met.

Daily care records were accurate and informative.

Is the service well-led?

Requires Improvement

The service was not well led.

Quality assurance systems had identified issues in relation to the timing of care visit but these issues had not been resolved.

Necessary notifications of incidents had not been submitted to the commission.

The provider was based in the service full time and there were systems in place to support staff outside of office hours.

South Western Care Services

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part as a result of safeguarding concerns reported to Cornwall Council and shared with the CQC. These concerns indicated that people's care needs were not being met as care visits were not being provided for the planned duration.

The inspection was carried out on 04 and 06 June 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

The inspection team consisted of two inspectors 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. The expert by experience spoke with 15 people who used the service and five relatives to gather feedback about their experience of the service.

Before the inspection we reviewed information we kept about the service and previous inspection reports. This included notifications of incidents. A notification is information about important events which the service is required to send us by law.

During the inspection we used a range of methods to help us make our judgements. This included talking to people using the service, speaking with staff and management, pathway tracking (reading people's care plans, and other records kept about them to check planned care was put into practice). We also reviewed various records including five care plans, five personnel files, call monitoring data and other records about

the management of the service.

Requires Improvement

Is the service safe?

Our findings

Staff told us the people they supported were safe. However, we received mixed feedback from people and their relatives in relation to this issue. Although people said they felt safe with their support staff, most people told us they did not feel entirely safe. This was because they did not know when their care would be provided. People and relatives' comments in relation to safety included, "I feel safe because I know someone is coming every day", "No [I don't feel safe] because I never know when they are coming", "No. I don't because I worry if they will turn up on time" and "I think [My relative] is safe because she lives with us, but if she lived on her own, I would definitely be concerned."

Prior to our inspection we received information of concern that indicated people's needs were not being met as care visit were not being provided on time and for the correct duration. We looked into these issues as part of our inspection and found care visits were regularly not been provided as planned.
We spoke with 20 people and their relatives to gather feedback on the service's performance. A total of 18 people raised concerns in relation to staff arrival times for care visits. Comments received included, "No they are never on time," "I don't know when they are coming. I have to wait for them to help me get up and go to the toilet. It can be any time between 7am and 9am and sometimes I am bursting (for the toilet). It's awful, waiting" and "No they are never on time. Sometimes they don't come to put [My relative] to bed until 11.30pm, it's too late, I am exhausted by then." We completed a detailed analysis of staff arrival times to six people's care visits, using daily care records and call monitoring data. We found there were significant variations in staff arrival times. For example, one person's evening visit was scheduled for 21:30. In one week the person's evening visits were more than 45 minutes early on four occasions and twice more than 30 minutes late. The earliest evening visit commenced at 20:40 while staff did not arrive until 22:25 for the latest visit. This had the potential to have a significant impact on people who required personal care.

Twelve people reported that their care visits were routinely shorter than planned. Their comments included, "They are meant to be here for half an hour but I get 20 minutes at most", "They are in and out as quick as they can" and "Sometimes I just get about 10 minutes. They have barely got the chance to say hello."

Daily care records and call monitoring data again confirmed people were not receiving care visits of the correct duration. For example, we looked at 30 care visits provided to one person over a three week period. This person was supposed to be provided with two 30 minute visits each day. Available call monitoring data showed the longest visit provided was for 31 minutes, with the shortest visits being seven minutes and an average visit length of 17 minutes. Overall of 15 hours of planned care this person had only received support for eight hours and 39 minutes.

The significant variation in staff arrival times and visit duration meant the support provided by the service was inappropriate and people's needs had not been met. This is a breach of the regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service employed sufficient numbers of staff to provide all care visits according to the visit schedules in use at the time of our inspection. However, these schedules did not include appropriate amounts of travel

time between consecutive care visits. Issues identified during this inspection in relation to visit scheduling are discussed in detail in the well led section of the report.

Records showed staff had completed infection control training and we saw that personal protective equipment, including disposable gloves and aprons were available from the service's offices. However, people told us this equipment was not always used during care visits and the service had received a complaint in relation to staff disposing of used gloves in bushes outside one person's home. These failures exposed people using the service and the wider community to unnecessary risk.

We recommend the provider reviews and updates staff training in relation to infection control practices.

Staff did not always understand the level of support people needed to safely manage their medicines and some people's care plans lacked detailed guidance for staff on the support they required. This had led to a small number of occasions where people had missed prescribed doses of medicines as staff had not prompted and reminded people to take their medicines.

We recommend that the service reviews recent national guidance on "Managing medicines for adults receiving social care in the community" and updates it's systems to ensure staff understand the level of support each person requires with their medicines.

Where repeat prescriptions had not been delivered to people who managed their own medicines the service had worked on the person's behalf to resolve these issues. Record showed the service had raised concerns about the availability of people's medicines with both the prescribing GP and pharmacist to resolve these issues. Where appropriate the service had completed additional visits and collected medicines directly from the pharmacies to resolve issues where medicines had not been delivered on time.

The service used a digital care planning and call monitoring system to allocate visits to specific members of staff. This system helped staff to record their arrival and departure time from individual care visits. During the inspection we reviewed the service's planned visit schedules, call monitoring data and daily care records. We found no evidence of planned care visits having been missed and no one told us their care visits had been missed.

Staff told us when changes were made to the planned visit schedules managers sent them a text message to highlight the fact that changes had been made. Staff said, "I get a list of visits to do on my phone" and "If they need to change your visits they send you a text that your list has changed." This highlighted to staff any changes in their visit schedules and helped reduce the risk of planned visits being missed as a result of staff becoming confused.

Information about local safeguarding arrangements was displayed in the service's office and staff understood of their role in ensuring people were protected from all forms of abuse and discrimination. Records showed managers had appropriately raised concerns about possible abuse with the local authority to ensure people's safety.

Risks in relation to people's care and support needs had been identified and assessed. People's care plans provided staff with guidance on the action they must take to protect people from each identified areas of risk. For example, where risks had been identified in relation to skin integrity staff, were provided with instructions to monitor any red areas or marks closely and immediately report to managers any changes observed. Records showed the service had made appropriate referrals to specialist nursing teams where concerns in relation to skin integrity had been identified.

There were systems in place for the recording and investigation of any accidents and incidents that occurred. Where lone working staff had been intimidated by people's behaviour changes had been made to visit schedules, to enable visits to be provided by two members of staff. Where appropriate these concerns had been reported to service commissioners and community health professionals to ensure the safety of both the person and their support staff.

The service had procedures in place for the prioritisation of people's care visits during periods of adverse weather. These systems had worked appropriately during the winter.

The service had suitable and safe recruitment procedures in place. All necessary pre-employment checks had been completed to demonstrate staff were suitable for employment in the care sector. These included references from previous employers and adults first checks to ensure staff were not barred from working with valuable adults. These adults first checks were completed before new staff shadowed experienced carer's providing support as part of the induction process. Enhanced Disclosure and Barring Service (DBS) checks were completed for all staff before they were permanently appointed.

Good

Is the service effective?

Our findings

The service had appropriate systems in place to assess people's care needs. Information provided by commissioners was reviewed as part of the assessments process and combined with details from hospital discharge teams to ensure the service had a good understanding of the person's needs and preferences before agreeing to provide support. Once the service had agreed to provide a package of care an assessment visit was arranged where senior staff met with the person at home or in hospital to review their specific needs to ensure they could be met. Initial care plans were developed by combining information gathered during the assessment visit with information provided by commissioners and where possible health professionals.

When new staff were appointed they completed an induction training package during their first two weeks of employment. This included training in topics the service considered mandatory and shadowing experienced care staff to learn how to meet people's individual care needs. Staff new to the care sector then completed the care certificate training during their first three months. This nationally recognised training programme is designed to provide staff new to the sector with an understand of current good practice.

Staff were sufficiently skilled to meet people's needs and records showed training in topics the service considered mandatory including; moving and handling, first aid, and safeguarding had been regularly updated and refreshed. Staff were also able to access additional training in areas they were particularly interested and records showed some staff had recently completed further training in the stroke pathway, dementia care and end of life care. Staff training records showed all staff had been supported encouraged to compete level 2 diploma qualifications in care.

All staff received practical manual handling training using equipment available in the day care centre the provider operated. People and their relatives told us staff had a good understanding moving and handling techniques. Their comments included, "Yes the staff know what they are doing", "We use a stand aid and staff are good at it" and "[My Relative] has a hoist. All of the staff know what they are doing."

Staff received regular support and supervision from managers and team meetings had been held regularly. Records of these meetings showed they had provided opportunities for staff to share information about changes to people's needs and for manager to update staff on changes planned within the service.

Care records showed people were supported to manage their food and fluid intake. Care plans included information about people's dietary preferences and, where relevant, specific guidance on how individuals liked their meals to be prepared. For example, one person's care plan stated, "[Person's name] likes warm milk on her Weetabix."

People were supported to access external healthcare services and, where necessary, the service had made appropriate referrals for additional support. Records showed the service had provided support and transportation to enable people to attend outpatient appointments. Where professionals had provided advice or guidance to staff this was incorporated in the person's care plan.

Care plans instructed staff to seek consent before providing support and records showed people were able to decline planned care. One staff member told us, "I don't force people to do anything. I offer and document that if they refuse."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The provider had some understanding of this legislation and staff records shows some staff had completed training in this area. However, it was clear from people's care records that these issues were not fully understood. We saw examples of contradictory information about people's capacity to consent to care within individual care records. In addition, relatives had signed consent forms on people's behalf where it was not clear they had the necessary legal authority to make these specific decisions.

We recommend training for the service's senior staff is refreshed and that additional systems are introduced to ensure the service has accurate records where people have appointed powers of attorney.

Requires Improvement

Is the service caring?

Our findings

Most people told us they were happy or fairly happy with the care they received from their care staff. However, this praise also included negative comments in relation to the timing and duration of the care visits.

People's comments in relation to their care staff were mixed and included, "The staff are OK, some nicer than others", "The staff are very friendly and polite", "They are good, I can't fault them." and "Some staff are better than others. None are awful but none are brilliant either".

Visits schedules showed people were supported by a variety of staff each week. When we asked people if they had a good relationship with their care staff we were told, "I can't say because I get different ones every week practically." The variation in staff rotas meant it was difficult for people and their support staff to get to know each other well.

Care plans included information about people's life histories, backgrounds, interests and hobbies. This information was provided to help staff who did not know the person well to recognise how the person's background could impact on their current needs while providing useful prompts to identify topics of conversation the person might enjoy.

Information about people's communication needs was recorded within their care plan. These documents provided staff with detailed guidance on the support the person needed with communication and to access information. For example, one person's care plan stated, "[Person's name] can communicate with others but does find it difficult and gets fatigued and confused if too many questions asked." Where people used hearing aids or glasses this was recorded and staff were provided with guidance on how people preferred to be supported with these aids.

The service employed some male care staff who regularly worked with female carers to support people who needed help from two staff due to their mobility needs. Some people had expressed preferences in relation to the gender of their carer and records showed complaints had been received where these preferences had not been respected. We discussed this issue with the provider who explained that the use of male care staff had been clearly explained to people during the assessment process. People had been advised that the service would endeavour to respect people's preferences but this could not be guaranteed during periods of staff sickness. Where people had expressed preferences in relation to the gender of their care staff, this was recorded in the service's visit scheduling system. This meant that when a male member of staff was allocated to the visit and an alert was generated to highlight to managers that this was contrary to the person's wishes.

We investigated three occasions where one person's preferences had not been respected. On each occasion female staff had been initially allocated to provide the visit but had become unwell during their care shift. Male staff had only been allocated when the service had been unable to supply alternate female staff. This meant the service had done everything possible to respect people's wishes in relation to the gender of their

care staff.

People were encouraged and supported to make decisions and choice about how their care was provided. For example one person's care plan stated, "Carers need to ask what support [Person's name] requires each visit" while another person's care plans said, "Assist to dress and give [person's name] the option of picking clothes to wear as she likes to choose her own clothing."

The service respected people's rights to take risks and make unwise decisions. Staff had become concerned that a person's behaviour could expose them to significant risk and had reported these concerns to their managers. A meeting had been arranged with the person to explain and discuss these concerns. The person had capacity and recognised they were taking a risk but wished to continue to do so. The service had recorded details of their safety concerns and asked the person to formally recorded their decision not to accept support in this area. This showed the service had appropriately highlighted safety concerns while respecting the person's decision and choices.

Requires Improvement

Is the service responsive?

Our findings

The service did not have appropriate systems and processes in place to ensure all complaints received were documented, investigated and resolved. The service did maintain a complaints log however, this did not include details of all complaints that had been made. We identified additional complaints that had been recorded in individual communication logs and through feedback questionnaires. This meant the provider did not have an accurate overview of the number of complaints that had been received.

Where people had made complaints, these had not been investigated and resolved. There was no evidence the service had formally responded to complainants explaining what action or changes had been made to resolve issues that had led to complaints. For example, one person had raised a complaint about a care visit having been provided 53 minutes late. This complaint had not been formally recorded as a complaint and the only evidence of investigation into the complaint was a note stating, "Checked rota time was a one off". There was no evidence the service had responded to the complainant detailing the findings of any investigations completed or of any action taken to prevent similar incidents from reoccurring.

We found that the service regularly received numerous complaints in relation to the timing of care visits. Staff meeting minutes and correspondence records showed details that some complaints had been shared with staff and discussed. However, there was a lack of evidence to show action was taken or changes made to visits schedules to resolve these issues.

People consistently reported the service had failed to respond to their complaints. People's comments included, "I spoke to them (Managers) and they said they would try to sort it out but they didn't really, so I didn't ask again", "I have had to draw a few things to their attention but they don't really do anything about it", "I have complained but they don't listen. They can't change people I suppose" and "I have mentioned things to carers to give them a chance to buck their ideas up before complaining. That usually does the trick because they won't listen in the office."

Where relatives had made complaints, people told us these were treated more seriously and sometime led to issues being resolved. For example, one person said, "My daughter complained and it got sorted straight away." The person went on to say they had complained about the same issue previously but, "They did nothing".

Relatives comments in relation to complaints were more positive that those of people supported by the service and included, "They were turning up after 10pm for [My relative's] bedtime so I complained and now its 9pm. I'll complain again if it slips" and "I have made two complaints about [My relative's] care and they have both been resolved."

These failures to adequately record, investigate and resolve people's complaints meant the service was in breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Senior staff completed assessments of people's care needs before the services first care visit. This

information was combined with details from care commissioners to form the person's initial care plan. Assessment documentation was available in all of the care plans we reviewed however, we noted some instances where these records had not been fully completed. This meant during initial care visit staff may not have been fully aware of people's care needs. After the first week of care provision senior staff again visited people at home to review the person's needs and make any changes to the care plan necessary to ensure the service met the person's expectations.

Overall, people's care plans provided staff with sufficiently detailed guidance to ensure people's needs were met. Each person care plan included specific information about the support that required during each care visit along with details of the level of support the person normally required with specific tasks. For example, one person's care plan stated that they were normally able to wash most of themselves independently but "needs help to wash back and feet." Staff told us the care plans were sufficiently detailed and their comments included, "The care plans are ok. There is a care plan in each house."

People's care plans had been regularly reviewed and updated where significant changes in needs were identified. People told us they had been involved in both the development and review of their care records and that these documents accurately reflected their support needs. Comments received from people and their relative in relation to the care planning and review process included, "I told them what I needed and that's what I get", "I have [My care plan] here and it's right", "I felt fully involved in [My relative's] Care Plan" and "My care needs have changed over the years so it has always been updated." Were people had specific needs, for example in relation to the positioning of pillows and pressure reliving aids staff where provided with detailed guidance on how exactly these items showed be positioned to ensure the person's needs were met.

Daily records were completed by staff at the end of each care visit. These recorded the arrival and departure times of each staff member with details of the care provided, food and drinks the person had consumed and information about any observed changes to the person's care needs. These records consisted of a combination of tick box records of specific tasks completed and a written narrative of the support provided. This included information about the person's mood and any observed changes in care needs. These records were detailed and provided an accurate account of the care and support staff had provided.

People were able to request specific changes to the timing of their planned visit to enable them to attend various events and appointments. Where these requests had been made, daily care records showed visit times had been altered to meet the person's needs. Daily care records also showed the service had responded promptly to address issues reported to the service following care visits. For example, one person had contacted the services on call manager as staff had left but forgotten to ensure the television remote control was within reach. An addition visit had been provided in the late evening to resolve this issue.

The service recognised importance of supporting people to remain at home towards the end of their lives. There were systems in place to records details of how people wished to be support at this stage of life.

Requires Improvement

Is the service well-led?

Our findings

South Western Care Services provides support to people in their own homes in rural areas of southern Cornwall. This meant staff often had to travel significant distances on rural roads between consecutive care visits. We reviewed the service's visit schedules and found staff, were generally allocated five minutes of travel time between care visits. This was not appropriate and did not accurately reflect the time needed to travel between visits. We compared travel time allocated on visits schedules with an estimate of the time necessary to travel between people's addresses using online mapping software. We found numerous examples where staff had been allocated five minutes to travel journeys which required more than 15 minutes to complete. These failures of the service's visit planning systems meant visit timings were not achievable and staff were unable to meet people's care and support needs

Staff knew visit schedules did not accurately reflect the time needed to travel between care visits. They told us, "Travel time means some visits are shorter than they should be but it is only normally tablet (medicines) visit that are short", "There's not enough travel time, the shortage of travel time has a knock-on effect on the time spent with people providing care" and "I don't think people are always getting the service they are paying for. That is mainly down to staff rushing and not staying for the time they should." One staff member summarised the current situation stating, "We need better rotas and the correct number of carers with a passion for the job." While one person told us, "It's not the girls fault, it is their rota."

The service had systems in place to gather people's feedback about the quality of care and support they received. Telephone surveys were regularly completed and everyone we spoke with confirmed they had been asked for feedback on the service's performance. Records showed the service had regularly received negative feedback in relation to visit timing including, "Overall happy but punctuality and regularity of correct times could improve", "Carers seem to be rushed" and "The times worked when first started but then rotas changed and now times can be all over the place."

It was unclear what action had been taken to in response to this feedback as people and staff repeatedly raised concerns about these issues. Of the 20 people we spoke with only five said they would be happy to recommend South Western Care Services.

As part of the provider's quality assurance systems, office based staff had completed an analysis of visit durations and staff arrival times when care records were returned to the office. This analysis also showed people were regularly receiving short visits and that care visits were not being provided on time. There was no information to show what action had been taken in response to the finding of this analysis.

These quality assurance systems meant the provider was aware the service was not meeting people's needs but there was no evidence available to demonstrate any decisive action had been taken to resolve the issues. Staff meeting minutes showed concerns in relation to visit timings had been regularly discussed and provider told us the service aimed to arrive with 30 minutes of the planned arrival time and to provide a minimum of 90% of the planned call duration. However, these targets were routinely missed as visit schedules were unrealistic and did not included adequate travel time. It was thus impossible for staff to

provide care visits on time and for the planned duration.

The provider's systems for the review complaints were not appropriate. Where complaints had been received these had not been investigated. The service's governance systems had failed to ensure action was taken in response to complaints received to improve the it's performance and the quality of care provided. People had lost faith in the service's complaints procedures and their comments included, "There's no point complaining is there. They can't do anything about it", "There is no point complaining, it's their rota" and "They (management) won't do anything about it."

The service's quality assurance systems were not effective and where issues where identified they had not been resolved. This meant the service was in breach of the requirements of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider recognised there were significant issues with the service's current visit schedules and told us, "We haven't taken on any additional packages recently because we are at capacity. I am not prepared to take on packages if I am not sure we can cover them." Following the inspection the provider gave notice on a number of care packages to enable visit schedules to be rationalised. There were also plans in place for the introduction of a new digital visit planning and monitoring system.

The service had not notified the commission of significant events and incidents that had occurred. These issues were discussed with the provider during the first day of our inspection who did not have a clear understanding of the notification requirements. Following the inspection, the service submitted four notifications to the commission detailing specific safety incidents that had occurred.

The failure to submit notifications without delay was a breach of regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

The service was led by the provider who was based in the service full time and supported by a team of managers with defined roles and responsibilities. Staff told us, "They do answer the phone if you ring" and we found there were appropriate on call arrangements in place to support staff outside of office hours.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Necessary notifications about significant incidents had not been submitted to the commission. This was a breach of regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care visits were not provided on time and for the full duration. This is a breach of the regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints received had not been appropriately recorded, investigated and resolved. This was in breach of regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service's quality assurance systems were not effective and where issues where identified they had not been addressed and resolved. This was a breach of the requirements of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

A warning notice was issued.