Diamond Resourcing Plc

Better Healthcare Services (Norwich)

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 25 August 2016 and was announced.

Better Healthcare Services (Norwich) provides a domiciliary care service to people living in their own homes. At the time of our inspection they were providing a service to 104 people living in the Norwich and North Norfolk areas

At the time of the inspection, the service did not have a registered manager in post. 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. However, a manager had been appointed and had started four days prior to our visit. The service's registered manager had left in June 2016 and the operations manager had been overseeing the service in the interim.

We last inspected this service on 17 February 2016 where we found that the service was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was in breach of six regulations relating to person-centred care, need for consent, safe care and treatment, receiving and acting on complaints, staffing and good governance. Following the inspection in February 2016, the service sent us a plan to tell us about the actions they were going to take to meet the above regulations.

At this inspection in August 2016, we found four continued breaches, and one new breach, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to person-centred care, dignity and respect, receiving and acting on complaints, staffing and good governance. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

The provider had failed to have effective systems in place to improve the quality of the service. No processes were in place to assess and monitor the service and the negative impact this was having on people. Where people had raised complaints or concerns about the service they received, these had not always been recorded, investigated or addressed.

People's needs were not consistently being met due to unavailability of staff and disorganised management and administration of the service. People had experienced a number of missed, late or cancelled calls and this had, in some instances, had a negative impact on their physical or emotional wellbeing. People did not consistently receive a roster so were unaware of who would be assisting them or whether the call had been covered. This caused people considerable anxiety.

The service had caused distress to some of the people whose preferences they had not met. People were receiving assistance with their personal care from male carers when they had requested female only ones. The times the service agreed they would provide care and support were not always met, with some calls being over an hour late. People's dignity was not always maintained as result.

There were not enough suitably trained staff to meet people's needs. Some staff had not received training as specified by the provider nor an appraisal. No spot checks had been completed to ensure staff were competent in their role although some had received this in relation to medicines administration. Staff had not received regular supervision.

The communication skills of the office staff was poor. People told us that they didn't receive correspondence from the office and were not kept informed of changes to the service in general or to the personal service they received. Staff also experienced poor communication in regards to their role and what was expected of them. They often received their rotas late or, if they were received, were not accurate.

The provider had not gained recent feedback on the service and people did not feel listened to by the office staff. They spoke of concerns not being addressed and phone calls not being returned. They were unaware of the recent changes with the management of the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

The CQC is required to monitor the Mental Capacity Act (MCA) 2005 and report on what we find. Assessments on people's capacity to make decisions had been completed in line with the MCA. Where people's relatives had legal authority to make decisions on their behalf, the service had not gained confirmation as to what specific decisions they had the authority to make.

Processes were in place to identify, assess and manage risk. The personal risks associated with the people

who used the service, and staff, had been recorded and managed. Accidents and incidents were few but there was a policy in place to manage these. Staff had received an induction where the risks associated with safeguarding had been covered. The service had a recruitment process in place that helped to reduce the risk of employing people who were not suitable to work within their service.

People received their medicines as the prescriber intended and staff were aware of people's needs in relation to their health and nutritional requirements. Assistance was received as required to access healthcare services.

People spoke highly of the caring nature of the staff that delivered the hands on care and support. They told us that staff delivered care as required and in a manner that respected their privacy and independence. They told us they were kind and compassionate.

People had been involved in the development of their care plans and those we viewed contained enough information for staff to meet people's individual needs. However, staff reported that the quality of care plans varied and that some people did not have care plans in place.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People did not receive the service they had agreed with the provider. The service had a high number of missed, late or cancelled calls resulting in people's needs not being met.

Processes were in place to help protect people from avoidable harm and abuse.

People received their medicines as the prescriber has intended and good practice was followed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not receive regular training, supervision, appraisal and support in order for them to perform their roles.

People's capacity to make decisions had been assessed as required by the MCA. However, where relatives had the legal authority to make decisions on people's behalf, the service had not gained confirmation on what specific decisions they had the authority to make.

People received support to meet their health and wellbeing needs as required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's preferences were not always met and they did not receive the information they needed at a time they wished for it.

People received care and support from staff that were kind, caring and respectful of people's wishes and feelings.

The care staff understood the importance of choice, dignity, privacy and independence and supported people in a way that promoted this.

Is the service responsive?

Inadequate

The service was not responsive.

The service's failure to provide care and support as agreed was having a negative impact on people's health and wellbeing.

Complaints and concerns were not consistently managed, logged, investigated or responded to.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had failed to have systems in place to assess, monitor and improve the quality of the service.

The impact of the issues highlighted in this report had not been identified by the provider.

Suitable resources were not in place to ensure a safe, effective and caring service was delivered at all times.

Better Healthcare Services (Norwich)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 25 August 2016 and was carried out in response to concerns received by the Care Quality Commission. The provider was given 24 hours' notice because the location provides a domiciliary care service. The management team sometimes spends time away from the office supporting staff and the people who use the service. Notice was given to ensure the management team was available to assist our inspection. The inspection was carried out by two inspectors.

Before we carried out the inspection we reviewed the information we held about the service. This included statutory notifications that the provider had sent us in the last year. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law. We also contacted the local authority safeguarding team and the local authority quality assurance team for their views on the service.

During the inspection we visited the service's office, spoke with eight people who used the service and ten relatives. We also spoke with the director of homecare, an operations manager, the manager, a care coordinator, a senior care assistant and seven care assistants.

We looked at the care records for eleven people who used the service. We also viewed records relating to the management of the service. These included three staff recruitment files, complaints and compliance trackers.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection carried out on 17 February 2016, we found that the service had failed to deploy enough staff to meet people's care and support needs. This was because people experienced missed or late calls and did not receive the service agreed with the provider. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, carried out on 25 August 2016, we found that the provider had not made sufficient improvements and was still in breach of this regulation.

People who used the service did not always receive the care and support as agreed with the provider. This was because there were not enough staff to meet people's needs. Out of the 13 people we spoke with regarding this, people who used the service and their relatives, nine told us that the service had either missed a planned call, arrived considerably later than had been agreed or only one staff member had arrived when two were required.

One person told us that the service had telephoned them to say that a staff member was off sick and that their call would be an hour and a half late. They told us this would mean they wouldn't get assistance to get out of bed till midday. The person told us, "I said to them if they can't get someone here by ten o'clock then forget it. No response so they cancelled it." Another person told us how their relative had to step in frequently to assist the person with meal preparation due to staff not arriving. One relative we spoke with said, "Sometimes there are huge discrepancies, especially at weekends, we often have 'no shows' where no one turns up at all – its hit and miss." Another relative said, "Two weeks ago the service phoned [family member] to say there was no one available for the regular lunchtime call. [Family member] didn't get lunch or use the commode. It was quite distressful." A third relative told us that when staff did not turn up for planned calls, their family member did not receive assistance to rise in the morning and take their medicine. They told us that they required this medicine to maintain their health condition and wellbeing. This relative told us that this happened on average once or twice a month. They said, "I dread calling to find [family member] still in bed."

Out of the nine care staff we spoke with who delivered care to people who used the service, seven told us they were regularly late for planned calls. They told us that this was because they were not given enough travel time between calls. Some staff spoke of journeys taking around 15 minutes but only getting five minutes on their schedule. One staff member said, "Often the lunch visit is cracking into dinner. I feel so embarrassed." Another staff member told us that when they arrived for a lunchtime call they often found that family members were already preparing the person's lunch as the call was so late. A third staff member explained how she had discussed travel time with the service. They told us they had asked for more time between calls as they were arriving late. The staff member told us that the service had refused to do this and gave the calls to another staff member instead.

We looked at the records for missed and late calls. Between 8 June and 19 August 2016, the service had 77 missed, late or cancelled calls. Forty-two of these calls were late by over 30 minutes and 11 were missed altogether. Twenty-four calls were cancelled by the people who used the service. This was because the

provider could not deliver the visit at the time agreed.

When we discussed the missed and late calls with the operations manager and the director of homecare they told us that these were due to staff sickness and historic poor management of staff member's annual leave. They also told us that there had been a high turnover of staff which had also contributed.

These concerns constituted a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection carried out on 17 February 2016, we found that, although the service had identified the risks to people who used the service, these had not been consistently acted upon in order to keep people safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, carried out on 25 August 2016, we found that the provider had made sufficient improvements and were no longer in breach of this regulation.

The service had assessed, reviewed and managed the individual risks to the people who used the service as well as the risks to staff members. These included risks associated with the working environment, security and safety. The individual risks to people had also been identified and these included those associated with falls, transfers, personal care and behaviour. However, the risks associated with people receiving missed and late calls had not been identified, assessed or managed.

The people we spoke with who used the service told us that they felt safe whilst receiving care from the staff of Better Healthcare Services (Norwich). One person told us, "I've never felt unsafe. I'm pretty confident with the staff, they make me feel safe." Another person said, "Usually it's a regular carer. When they're off it's a different one but you get to know them all. I feel completely safe." People's relatives had no concerns over safety. One said, "There's never been a problem with safety and [family member] feels safe."

The service had processes in place to help protect people from the risk of abuse. These included staff training in safeguarding vulnerable adults which every staff member received during their induction. Staff also had to complete a written test in regards to this to ensure their understanding in this area. The staff we spoke with confirmed they had received this training. Although there had been no reports of any accidents or incidents since our last inspection, the service had a policy in place should this arise.

We checked the recruitment records for three staff members to see whether measures had been taken to ensure that only people suitable to work in the service had been employed. We saw that references had been requested and a check with the Disclosure and Barring Service (DBS) completed. A DBS check establishes whether a potential employee has a criminal record or is barred from working within the care sector. The service had also requested identification, including photographic, to confirm the staff member's identity.

People told us that, where staff assisted them to take their medicines, these had been managed safely and without concern. People's relatives also had no concerns in relation to medicines administration. One told us, "The staff have a MAR sheet and it all gets noted and registered."

Where staff administered people's medicines, from the limited records we viewed, we saw that this followed good practice. The medicines administration record (MAR) charts were clear and legible and had been fully completed to show that medicines had been administered as the prescriber had intended. Where medicines hadn't been administered we saw that clear records were in place to explain the reasons behind this. We saw that a number of staff had also had their competency to administer medicines completed although

some staff had not received this for over 12 months.

Requires Improvement

Is the service effective?

Our findings

One person who used the service told us that new staff often arrived to assist them without knowing how to use a particular type of hoist. They told us, "The new carers arrive here and have only ever dealt with one type of hoist. They say they've never used one of them before. I think that a number of new staff don't always come well trained. I don't think there's enough follow up or management support." When we spoke with staff about this, some of them agreed that they needed more training in the different types of hoist as well as more 'hands on' experience during training.

All the staff we spoke with told us that they had received an induction. However, most staff told us that they didn't think it prepared them adequately for their role. Two staff members described the induction as 'horrendous' whilst another described it as 'very basic'. Other staff told us that what training they did receive in some areas of their role was not enough. Examples included medicines administration, continence care and supporting people living with dementia. However, two more recently appointed staff told us that they felt the induction was 'okay'. These staff confirmed that they had undertaken job shadowing a more experienced member of staff as part of their induction however this was limited. When we looked at the training records, we saw that 13 out of the 35 staff the service employed had not received the training as the provider had specified. One staff member told us that they chose not to assist people with more complex needs as they didn't feel the level of training they received was enough to meet their needs. They said, "It doesn't feel safe."

Staff told us that they hadn't received regular supervision sessions and that they didn't always feel supported in their role. One staff member told us how unsympathetic the management team had been when they had been unwell and unable to work. Another newly appointed staff member said, "I don't know who to contact" when we asked what they would do if they had any concerns. They went on to say that no one had met with them since they started in post to see how they were getting on in their role. A third staff member said, "[The service] can't keep staff." Staff told us that communication within the service was poor and that they were not kept up to date with all the recent management changes.

Most of the staff we spoke with told us that they had not received any 'spot checks' by the service to ensure they were competent in their role. Other than competency checks around medicines administration, the records we viewed confirmed none had taken place. Records also showed that only three staff members had received a supervision session and that these had been completed in August 2015.

These concerns constituted a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection carried out on 17 February 2016, we found that the service was not adhering to the principles of the Mental Capacity Act 2005 (MCA). This was because the people who used the service were not fully protected against the risks associated with other people making decisions on their behalf. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, carried out on 25 August 2016, we found that although further improvements were

required, the service had made sufficient progress to no longer be in breach of this regulation.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

The service had assessed people's capacity to make decisions where necessary and involved family members in best interests decisions. These had been recorded. However, where relatives had legal authority to make decisions on their family member's behalf, the service had not gained confirmation in regards to what specific decisions relatives had the authority to make. The operations manager told us that they requested to see copies of these documents during assessment but that copies were not kept. We saw that staff had received training in the MCA. We concluded that, although further improvements were required, the service was no longer in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed opinions when we asked them whether they felt staff had the skills and knowledge to perform their role. One person who used the service said, "Yes, the staff are very good, they have a good idea of what's required." Another told us, "Most of the staff are experienced." One relative we spoke with said, "Most of the staff know what they're doing. I think they're capable. They don't leave [family member] needing anything." Another relative told us, "I can see from how confident the staff are that they are quite knowledgeable about their post, I'm quite happy they understand [family member's] illness."

However, some people felt that some staff did not always have the skills required. One person who used the service told us, "Sometimes I get someone [staff member] who doesn't quite know what to do but my regular ones know exactly what to do". On relative we spoke with said, "Some staff have the skills and some haven't".

Where needed, people received assistance with meeting their nutritional and health needs. People told us staff prepared meals for them as required. One relative told us that the staff member who assisted their family member to shop had a good understanding of their nutritional needs and requirements. The relatives we spoke with felt staff were mostly responsive in meeting their family member's health needs. One told us, "Oh yes, I think they would call a doctor if [family member] needed one." Another relative said, "[Family member's] main carer would unquestionably call a GP."

Requires Improvement

Is the service caring?

Our findings

Due to missed and late calls and people's preferences not being met, people's dignity was not always maintained.

Staff told us of a number of incidents that demonstrated people had not received a service that promoted their dignity. One staff member told us that male staff members had been sent to assist a person where this was culturally inappropriate showing disregard for the person's faith. Another staff member told us about a recent incident where the office staff sent a male carer to a person who had requested assistance with personal care from a female carer only. The staff member told us that this had resulted in the person not receiving assistance with their continence needs for 24 hours. A third staff member told us about an incident where staff arrived to assist a person who had passed away. They told us that the office staff had been aware of this but had not passed it on to the staff. This could have caused considerable distress. One relative explained how distressing it was for their family member to wake up to find a male carer in their bedroom. They told us that they had requested a female carer 'time and again' but that this had not been adhered to by the office staff.

These concerns constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt respected by the staff that visited them. They told us that, whilst providing their care and support, the staff were very good at maintaining their dignity. One relative we spoke with said, "Staff treat [family member] with great respect and always affection which is really nice." Another's person's relative told us, "Staff are respectful and dignified. When [family member] has an accident they take them to the bathroom and close the door. They protect their privacy." A third relative commented, "I think staff are pretty good. They bathe [family member], wash their back and leave them to do the rest but stay there discreetly."

All the people who used the service, and their relatives, spoke highly of the caring, kind and patient nature of the staff that supported them. One person said, "All the staff are splendid people and all have the welfare of the people in mind." Whilst another described the staff as 'happy' and 'cheerful'. One relative said, "They're the best carers in the world, they're brilliant." Another told us, "The main carers have been outstanding." Whilst a third said, "They're all very caring."
Staff encouraged people's independence and offered them choice. One person who used the service told us, "The staff I have regularly are very good about providing for my needs but letting me do the rest." Another person said, "Yes, staff do encourage me to be independent, they say 'we would rather you continue to keep yourself as independent as possible'. The staff are friendly and efficient." A third person said, "I am fully involved. The staff are super, polite, respectful – I can't think of any occasion when that's not been the case."

People told us that they had been involved in planning the care and support they received and wished for. They told us they had received a visit from the service initially where their needs were discussed. One person said, "They usually send someone to establish a care plan." The relatives of those people who used the

service told us that they had been involved as appropriate although the regularity of this varied.

When we talked with staff they demonstrated that they knew the needs and preferences of the people they supported. For example, they could tell us people's health needs and how this affected them. One staff member told us about a person they supported who was living with dementia. They demonstrated that they had the knowledge of how to support this person in a way that promoted their dignity and maintained their emotional wellbeing.

Inadequate

Is the service responsive?

Our findings

At our previous inspection carried out on 17 February 2016, we found that the service was not meeting people's needs in a person-centred manner. This was because people's care plans did not contain enough information for staff to provide care in an individual manner. In addition, people's needs were not being met due to the unavailability or inconsistency of staff. The service had also failed to ensure people received the information they required at a time they wanted it. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, carried out on 25 August 2016, we found that the service had not made sufficient improvements and was still in breach of this regulation.

People told us that their needs were met when they received consistent care and support from their regular carers. However, they told us that issues arose when their regular carers were not available. One person told us, "They can only provide care to my satisfaction five days a week when the regular carer is available" One relative we spoke with said, "[Family member] doesn't cope with change so any doubts over who's coming and they get very anxious about it. That alarms us."

One staff member told us how one person they supported required an early call. They told us that an early call helped the person to better maintain their health condition. The staff member told us that this person often didn't receive a call till mid-morning which resulted in them being in discomfort. In addition, the staff member said, "We are preventing them from getting on with their day." Another staff member told us that one of the people they supported cried when their personal care was supported by male carers. They told us that the person's preference was for female only carers but that the service did not adhere to this.

Staff did not consistently receive enough information, at the time they needed it, to provide the care and support people required or had agreed with the service. Most of the staff told us that they did not receive any information on the people they were due to visit prior to meeting them for the first time. Two staff members told us that for one person who used the service there was no care plan in place. Staff told us that they relied on this person's family member to tell them what their needs were. When we asked to see the care plan for this person, the service could not produce it.

People's views were not consistently acted upon by the service. Where people had requested care to be provided at a certain time, this did not always happen. One relative told us, "Care staff arrive later than agreed on all three visits, about an hour later than we would like." One person who used the service told us male staff had arrived twice in the last week when they had requested female only staff. They said, "The problem is shortage of staff." Another relative told us that occasionally their family member was assisted by male carers when their preference was for female carers. The relative felt this happened when the service was short staffed.

We saw from one care plan review that had taken place with a person who used the service that they had requested a female only carer. However, this had not been adhered to and we saw that a male carer had been sent for the weekend of 20 August 2016. When we discussed this with the operations manager, they

told us that they were not able to accommodate this person's preference at the present time due to a shortness of staff.

People did not always get the information and explanations they needed from the service at a time they wanted. Most people who used the service, and their relatives, told us that they did not receive a roster to tell them which staff member was assisting them and when. One person who used the service said, "The regular carers try and find out for me who is coming. Management don't do that, they're very good at promising to let you know but they never do." Another person told us, "You have to prise information out of the office staff. I had to start asking the office to send me a roster and eventually, towards a Friday evening, one is sent through." A third person said, "Staff have been switched around all over the place. I don't know who is coming hardly from one time to the next. They sent a roster to my relative this weekend but it turned out to be completely different." One relative we spoke with told us, "When the service started they said they would give you a roster each week but I've never seen one. Having one would be helpful."

The staff we spoke with agreed that the people who used the service did not receive regular rosters to tell them who was attending. One staff member told us that people relied on the carers to tell them. Another staff member told us that if people did receive a roster they were often not accurate. A third staff member told us that some people did not know they were attending when they arrived for calls.

These concerns constituted a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection carried out on 17 February 2016, we found that the service did not have effective systems in place to ensure complaints were investigated without delay. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, carried out on 25 August 2016, we found that the service had not made sufficient improvements and was still in breach of this regulation.

The service had failed to fully investigate all the complaints they had received and therefore had not taken necessary and proportionate action in response. People told us that the service had not responded appropriately to their concerns or addressed them to a satisfactory level. We asked people if they had reported any concerns and, if so, how this was managed and whether they were satisfied with the outcome. One person answered us by saying, "I've given up trying to contact them. They either wouldn't know, the person who can deal with it is not there or they promise to phone you back but don't." One relative said, "When I phoned to complain about a missed call I spoke to someone who said the manager was not available and couldn't put me in touch with anyone else. The email they gave me was incorrect."

We looked at the complaints records to see whether people's complaints and concerns had been logged, investigated and promptly and appropriately addressed. Only one complaint had been logged. However, from the people we spoke with we knew that other people had had concerns in relation to the service and that these had been brought to the provider's attention. However, there were no records in relation to these concerns.

For the one complaint on file, we saw that it had been investigated and a formal response issued to the complainant in good time. However, we noted that the formal response wasn't wholly appropriate. We saw that it imparted confidential information in relation to a staff member and offered no apology where it had acknowledged the provider hadn't delivered the service as expected. It did not contain further information about how to take action if the complainant was not satisfied with how the provider had responded to their concerns.

Whilst viewing other records, we found an additional written formal complaint dated May 2016. We asked to see that the complaint had been investigated, addressed and responded to. During our visit, the service could not demonstrate that this complaint had been addressed. We therefore gave the provider an additional 48 hours to provide us with confirmation that the complaint had been responded to. Within this timescale, the director of homecare confirmed that no response could be found. They did not offer any explanation for this nor confirm that they would be taking any additional action as a result.

These concerns constituted a continued breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the care plans for eleven people who used the service. This was to see whether their needs had been assessed and regularly reviewed. We looked to see that care plans were person-centred and individual to the people who used the service.

Although care plans varied in how often they had been reviewed, from the care plans we saw, we noted that they were person-centred and contained enough information for staff to be able to deliver the care and support people required. Most had been reviewed within the last 12 months.

The care plans we viewed contained basic background information on each person which helped staff to forge meaningful relationships with the people they supported. This included information on people's hobbies and interests and their thoughts on different aspects of the care and support they required. Goals and objectives were recorded that explained what the care and support aimed to achieve. We concluded that care plans were person-centred and met people's needs.

Inadequate

Is the service well-led?

Our findings

At our previous inspection carried out on 17 February 2016, we found that the service did not demonstrate good governance. This was because they had failed to have effective systems in place to assess and monitor the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, carried out on 25 August 2016, we found that the service had not made sufficient improvements and was still in breach of this regulation.

The provider had no effective system in place to assess and monitor the quality of the service they provided and therefore drive improvement. When we discussed this with the operations manager they told us that the only audits that should take place was in relation to daily records and MAR charts. However, these had not been completed for some months.

Although the service recorded all missed, late or cancelled calls, and had identified contributing factors, these were still occurring. Staff told us that they were not given enough travelling time between calls to people who used the service. Some of these staff had addressed this with the service however no action had taken place as a result. This resulted in a number of late calls. One staff member told us that they started before their allocated start time to try and prevent people receiving late calls. The service had not taken responsibility for the missed, late or cancelled calls and the impact this was having on the people who used the service.

When we discussed this with the senior managers, they told us these calls were as a result of staff calling in sick or on annual leave. However, effective actions had not been taken in response nor had the service assessed, monitored or audited the impact this was having on the people who used the service and their relatives.

Some of the people who used the service, along with their relatives, told us that they had raised concerns with the provider but had not been satisfied with the outcome. We saw that complaints had not been addressed appropriately or responded to. The service had failed to have an effective system in place to investigate complaints or concerns and take proportionate action in response.

Since our last inspection in February 2016, the service had put in place a tracker system that gave an overview and recorded any outstanding actions in relation to both staff and the people who used the service. For staff, these included such things as training, supervisions, spot checks, personnel paperwork and appraisals. For the people who used the service, it gave information on care plan review dates, medicines management and MCA information. Although some actions had taken place to address these outstanding actions, issues were still evident. For example, staff had not received supervisions or spot checks to ensure there were competent to perform their role. Not all staff had received up to date training or an appraisal. We concluded that the system was not wholly effective.

The service had failed to either identify or adhere to people's preferences and had not assessed the impact this had had on the people who used the service. When we discussed this with the operations manager they

were aware of some people's preferences but told us they couldn't be met due to staff shortages. The service had failed to consider, assess and monitor people's views and preferences and the impact this had had on them.

People, and their relatives, told us that their views and feedback on the service had not been recently sought and that they were not kept informed of changes. One relative said, "No, the service doesn't contact me. I would quite appreciate it when anything is going on." Another relative said, "The service is not very good at communicating with [family member]. Communication is important. If [family member] knew a different carer was coming, or coming later, they would not have to worry. It's the anxiety of not knowing." A third relative told us, "No one has contacted us from the office, we've no idea who's coordinating the service." When we discussed the recent changes of management with the managers at the service during our visit, we were told that people had not been officially informed of the appointment of the new manager.

Staff also told us that communication between the office staff and them was poor and impacted on the service delivered. One staff member said, "I never hear back if I email the office about a complaint or asking for information regarding a person [who uses the service]." Another staff member gave us examples of where they had concerns in relation to a number of people they supported. They told us they had contacted the office in regards to this but that no action had been taken. They told us they made all the necessary arrangements to ensure people's health and wellbeing. The staff member said, "Office staff don't seem to be dealing with this sort of stuff. I think they should."

Most of the people, their relatives and staff that we spoke with talked negatively about the way in which the service was managed and organised. One person who used the service said, "My main concern is we never know who's in the office, a letter would be welcome but we get no communication. I think that's dreadful considering they're supposed to be running the thing." Another person told us, "Ever since they took over in November, they've been awful." A third person said, "My carer is wonderful but the people in the office are disorganised. They never see the people receiving the care and they have not got the foggiest what's going on." A fourth person said, "The problems are all in the office." One relative said, "Our impressions since Better Healthcare took over are the service has been stretched, ongoing concerns, a service struggling to cope."

People told us that, although the hands on care they received was good, they wouldn't recommend the service. One person said this was because, "The right hand doesn't know what the left hand is doing. They don't seem to care or understand so unless you're lucky with the carer you get you don't stand much chance of getting the help you need." Another person told us, "The carers are fine but I wouldn't recommend the service. The [service] looks down on their carers." One relative said, "We would not recommend the service because we feel they are hardly coping." Staff agreed that they wouldn't recommend the service. One said, "They don't know what they're doing."

These concerns constituted a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not currently have a registered manager in post. However, a manager had been appointed and had started in post a few days prior to our inspection. They were aware of the need to make an application to register with the CQC.

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 9 HSCA RA Regulations 2014 Person-centred care The service had failed to do everything reasonably practicable to meet people's needs in a person-centred manner. Regulation 9(1)(2)(3)(a)(b)(c)(d)(e)(f)(g)

The enforcement action we took:

NoP

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Regulation 10(1)(2)(a)(b)(c)

The enforcement action we took:

NoP

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The service had failed to investigate and take necessary and proportionate action in response. Regulation 16(1)(2)

The enforcement action we took:

NoP

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service had failed to have systems or process in place to assess, monitor and improve the

	quality of the service. Regulation 17(1)(a)(b)(c)(e)(f)

The enforcement action we took:

NoP

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service had failed to deploy enough suitably qualified, competent, skilled and experienced staff to meet people's needs. Regulation 18(1)(2)(a)

The enforcement action we took:

NoP