Care at Home Services (South East) Limited

Care at Home Services (South East) Ltd - Crowborough

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

This inspection took place between 31 August and 12 September 2016. The inspection involved visits to the agency's office and telephone conversations with people, their relatives and staff between the beginning and end dates. The agency were given two working days' notice of the inspection. The agency provided 133 people with care in their own home. Most were older people or people who lived with long-term medical conditions.

People received a range of different support. Some people received infrequent visits, for example weekly support to enable them to have a bath. Other people needed more frequent visits, including daily visits, and visits several times a day, to support them with their personal care. This could include use of aids to support their mobility. Some people needed support with medicines and meal preparation. Some people needed visits from two care workers to support them with their personal care.

Care at Home – Crowborough, supplied a service to people in the small Sussex town of Crowborough, and rural areas in a wide catchment area around the town. The provider was Care at Home Services (South East) Limited who provides domiciliary care services to people from different offices across the South East of England.

Care at Home – Crowborough had 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.

The service was last inspected from 16 November to 15 December 2015. At that inspection, we found people's health and welfare was not protected because the provider did not have systems, which operated effectively, to assess, monitor and improve the quality of the service. The provider also did not maintain an accurate and complete record in respect of each person, staff and management of the service. The provider did not effectively seek, evaluate and act on feedback from relevant persons, to improve service provision. We issued a Warning Notice following the inspection and required the provider meet this Notice by 30 April 2016. Relevant improvements had not been made by this inspection.

At the last inspection we found care was not provided to people in a safe way. This was because the provider had not assessed risks to people's health and safety and was not doing all that was practicable to mitigate such risks. This was a breach of Regulation and we required the provider take action to address this. The provider stated in their action plan that they would have addressed the breach by 30 June 2016. At this inspection, a number of areas had not been addressed. These related to ensuring people had relevant assessments of safety, which were reviewed when necessary. The provider also continued not to take all relevant action to ensure the safety of people in relation to medicines and prevention of risk of infection. The provider had addressed some areas.

At the last inspection the provider had not ensured they had an effective and accessible system for identifying, receiving, recording, handling and responding to complaints. This was a breach of Regulation and we required that the provider take action to address this. The provider stated in their action plan that they would have addressed the breach by 30 June 2016. At this inspection, we found the provider had not taken all relevant action to ensure people's complaints and issues of concern were documented or that all issues of concern raised with them had been acted upon.

At this inspection we found the provider had not identified they were not working within their own policy on the Mental Capacity Act 2005 (MCA). The 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 provider had not ensured where they needed to provide care which might restrict people, that relevant assessments were in place and there was evidence that such care provision had only been provided in people's best interests.

At the last inspection we found people were not protected because the agency's recruitment systems did not ensure staff were of good character, and had the necessary qualifications, competence, skills and experience. We issued the provider with a Warning Notice in relation to this matter and required they met this Notice by 30 April 2016. At this inspection we found the provider had taken necessary action to ensure they had met the Notice.

People were not protected because the provider was not ensuring they always had suitably qualified, competent, skilled and experienced care workers who had received appropriate support, training and supervision as necessary. We issued the provider with a Warning Notice in relation to this matter and required they met the Notice by 30 April 2016. At this inspection we found the provider had taken action and had addressed the Notice. People and staff also confirmed staff were fully trained and supported in their roles.

People commented positively on the caring nature of the staff and said staff ensured they were safeguarded. People said staff contacted relevant healthcare professionals when they needed support from them, including in an emergency. They said where they needed support with meals, this took place in the way they wanted. People and staff said there were enough staff employed, so people did not experience missed visits.

During this inspection we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

The overall rating for this provider remains 'Inadequate'. This means that it remains in 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

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

CQC are taking enforcement action to ensure that Care at Home Services (South East) Limited provide safe and effective care.

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 always safe.

People did not always have relevant risk assessments and care plans to ensure their risk was reduced and where they did, they were not up-dated when relevant.

People were not always supported to take their medicines in a safe way.

People's risk of infection was not always reduced.

People were protected by the agency's recruitment policy.

Staff were aware of actions to take to safeguard people from risk of abuse.

People and staff said there were enough staff to meet their needs.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not have assessments completed in accordance with the MCA and the provider did not ensure they followed the MCA where decisions were being made in people's best interests.

The provider had taken action to ensure staff were supported, including by training, to meet people's needs.

People said staff knew how to support them with their healthcare needs.

Where people needed support with their food and drink, their needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

Confidentiality of people's personal information required

improvement.

People's records did not consistently support their individuality.

People were supported by staff who were caring and respected their individuality.

People were encouraged to remain as independent as they wished to be.

Is the service responsive?

Inadequate

The service was not responsive.

People continued to report their individual needs were not met in the way they wanted, particularly in relation to the timing of their visits and continuity of care workers.

Some people said the agency did not respond effectively when they raised matters of concern to them. The agency did not consistently maintain records of such concerns or actions taken in response to them.

People said their care plans met their needs.

Is the service well-led?

Inadequate

The service was not well led.

Several areas identified at previous inspections had not been addressed, as the provider stated they would be, so the provider's quality assurance systems were not effective.

The provider had also not auditing a range of relevant areas, so had not identified areas for improvement. Some records were not completed.

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

Care at Home Services (South East) Ltd - Crowborough

Detailed findings

Background to this inspection

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

This inspection took place between 31 August and 12 September 2016. The inspection involved visits to the agency's office on 31 August and 12 September 2016. On 31 August 2016, we also met with some of the care workers. Between 31 August and 12 September 2016, we spoke with people, their relatives and care workers on the phone. The provider was given two working days' notice of the inspection because the location provides a care service in people's homes. The inspection was undertaken by an inspector and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

We spoke with 27 people who received a service and their relatives. We spoke with 10 members of staff, the registered manager and three senior managers who worked for the provider.

During the inspection we looked at 10 people's records and nine staff recruitment, supervision and spot check records. We also looked at training records, quality audits and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found improvements were required because the agency did not have effective systems to ensure care was provided to people in a safe way. This was because the provider was not consistently assessing risks to people's health and safety and doing all that was practicable to mitigate such risks. This included management of medicines and risk of infection, as well as other areas relating to risk. This was a breach of Regulation 12. In their action plan, the provider stated areas relating to safety would be addressed by 30 June 2016. At this inspection, we found the provider had not taken action to address all relevant areas, although they had taken action in some areas. The provider therefore remained in breach of the regulation.

At the last inspection where people were prescribed skin creams, information was not included in files to show when skin creams were to be applied and to which parts of their body. This continued at this inspection. We looked at five people's files where they were prescribed skin creams, four of them did not include clear information. For example, one person's file documented three skin creams on one record, but four on another. There were no instructions as to where these creams were to be applied to the person's body or how often this was needed. When we looked at their daily records, these showed that one cream had been applied to a certain part of their body on one day. On the next day, a different cream was applied to this part of their body, and the first cream was applied to a different part of their body. In another person's records there were no instructions about the frequency of application of the skin creams or if they were to be applied 'as required' (prn). This meant it was not possible to assess whether incomplete records in their medicines administration record (MAR) were due to the skin cream not being required or because care workers had not applied the prescribed medicine. We asked care workers about applying skin creams where they did not have information on what to do. We received a variety of responses. Some care workers said they asked people what they were prescribed, but said this could be difficult when people did not know this information. Some care workers said they followed what had been written in previous daily records, but found it difficult when the record stated 'creams applied,' without stating which one. Although similar findings had been identified at the last inspection, the provider had not improved systems so people had their prescribed skin creams applied as directed by the prescriber, to ensure their comfort, health and well-being.

Although the provider stated in their PIR that no people were prescribed controlled drugs, care workers told us they had supported people with applying pain patches, naming a medicine which is a controlled drug. We asked the registered manager about this and they reported there were no people currently having such medicines applied. However, when we looked at the records of a person, their MAR showed they were having a pain patch applied a month before the inspection. The person had no instructions in their file about the type of pain patch prescribed and no instructions about rotating the sites where the pain patches were to be applied. This is necessary to ensure the effectiveness of the medicine and to reduce risk of skin damage. The provider's medicines administration policy did not make any reference to safe application or disposal of pain patches. The registered manager told us they had just introduced a record to document rotation of pain patches. This was not yet in use.

Although the provider reported in their PIR that they assessed people for risk of pressure damage, this had not happened in practice. Five people's files showed they had complex disability needs, including needing to be supported to move. None of these people had assessments about their risk of pressure damage or care plans about how their risk was to be reduced, although we were told some of them had pressure relieving equipment, such as air mattresses. This was not always documented. A person who had sustained pressure damage before the agency started providing them with care had records which only stated care workers were to, 'monitor very closely and report to the office.' They had no information about what staff were to monitor for or the areas of the person's body they were to observe. We asked care workers about what they did if they thought someone was developing pressure damage. They gave us inconsistent replies. Some care workers said they would mention it to the person's family, others said they would write a record in the person's daily record so other care workers could monitor the person's skin condition, some said they would document it on a body map. Some care workers said they would also report it to the office. The registered manager showed us information care workers were given on pressure damage, this showed the effect of skin damage on people. It did not emphasise key information relating to prevention of pressure damage such as the importance of regular changes in position for people or the correct use and monitoring of equipment. The registered manager kept a record of where people had pressure wounds, but they had not recorded where care workers had reported pressure damage like red areas. This meant they were not effectively ensuring people's risk was reduced and care plans updated when care workers made reports about early pressure damage.

Where people showed increased risk in other areas, risk assessments and care plans were not always promptly reviewed, to ensure their risk was reduced. A person's daily records from late June 2016 showed they needed increased assistance to move in bed, including the use of an aid. The person's last assessment and care plan was dated in February 2015 and did not relate to the person's current needs, as documented in their daily records. We asked the registered manager about this. They told us they were awaiting information from a healthcare professional so they could up-date the person's file. The registered manager had not ensured an interim assessment and care plan was put in place to ensure the person's current needs were met, until the relevant information had been received from the healthcare professional.

The agency cared for a person who had a particular type of catheter. The person had some information about the catheter in their records. However there was no information on how care workers were to ensure the person received adequate support with their hygiene, in the light of the type of catheter prescribed, including any instructions about care of the skin round the catheter. We looked at the person's records over a five week period in June 2016. We saw they had care needs relating to their catheter care on one occasion and had also sustained a urine infection on a different occasion. Despite this, the person's care plan had not been reviewed and updated to ensure they were appropriately supported with their hygiene and to ensure the person's risk of infection was reduced. The information which was available stated the person's leg bag was to be changed weekly. We looked at records for the person over a five week period. These showed only two records of their leg bag being changed during this period. The risk of infection for the person from not maintaining appropriate records of whether their catheter bag had been changed had not been identified and action taken to ensure the person was not put at additional risk of infection.

The provider continued not to provide care in a safe way to people. This was because they were not always assessing people's risk and doing all that was possible to mitigate such risks to people. This included risks relating to management of medicines and risk of infection as well as risk of pressure damage and people's mobility. This is a continued breach of Regulation 12(1)(2)(a)(b)(g)(h) of the HSCA Regulations 2014.

The provider had taken action in other areas to ensure the safety of people. People said they received the support they needed to take their medicines. One person told us, "I get the medication at the right time and

the right amount," and another "I am very happy they do this," about supporting them with their medicines. A person's relative told us about a person's medicines, "The carers always check she has taken it and they write it on the sheet." Since the last inspection the provider had provided information sheets to care workers in each person's file about the medicines they were taking. This included the reasons for the medicine and any side effects to be observed for. All of the care workers we spoke with were positive about the individual medicines sheets, saying they found this information helpful to them when supporting people.

Everyone we spoke with said they felt safe with their care workers. One person's relative said they were impressed by the way, "They make sure walk ways are clear before getting him up," so the person was safe in their home. Another person's relative said care workers, "Do notice things like bruises," and that they made a record of any bruising they had noted. We asked staff about their understanding of safeguarding people from risk of abuse. All were fully aware of their responsibilities and gave examples of what they would do if they suspected a person was at risk of abuse. One care worker told us, "Oh yes, I'd definitely take it further" if they had any concerns. Staff also knew about reporting concerns to the local authority safeguarding team if they felt prompt action was not being taken to safeguard a person from risk of abuse. One care worker told us, "I'd always go higher."

People had risk assessments in relation to areas such as risk of falling and their mobility needs. Some of these were very detailed and included a range of relevant information. For example, one person was documented as having several pets living with them and their risk assessment documented risks of tripping because of this and actions staff were to take to reduce the risk. Another person was documented as being a heavy smoker. The agency had information about an assessment from the fire officer on their file, to ensure the risk of fire to the person in their home was reduced as much as possible.

As the last inspection we found systems for disposal of potentially contaminated items were not consistent. People did not report on such issues to us during this inspection and confirmed staff always wore gloves when providing them with personal care and disposed of items correctly. The provider had revised its infection control policy since the last inspection.

At the last inspection, we found the provider's systems for assessing suitability of some newly employed staff and certain long-term staff did not ensure all relevant areas were considered. We issued a Warning Notice in relation to this area. The provider had met the Warning Notice. The provider had performed a full audit of employee's files since the last inspection and ensured they were complaint with Regulations. When we looked at the files of newly employed staff, they included all relevant information to ensure staff were safe to provide care to people, including police checks. Where staff had gaps in their employment history, this was probed at interview and a record made.

People told us they thought the agency had enough staff to ensure they were visited in accordance with their care plan. No-one said they had experienced any missed calls due to staff shortages. Staff also told us they felt there were enough staff employed, so they could follow people's care plans.

Requires Improvement

Is the service effective?

Our findings

At the last inspection, we found improvements were required to ensure the agency provided an effective service. While the provider had addressed some areas, they had not taken appropriate action in relation to ensuring they worked within the requirements of the MCA.

The 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 decisions made on their behalf must be in their best interests and be the least restrictive possible. We checked whether the service was working within the principles of the MCA. The agency's MCA policy followed guidelines. The provider had not identified they were not following their own policy.

Some staff told us about people who needed to have their medicines locked away for their safety. We asked the registered manager about this. They confirmed this was necessary at times and showed us a person's records where this was taking place. The person had no mental capacity assessment on file completed either by their social worker or the agency, although there were some emails on their file, about actions being taken by the agency. There was also no information that decisions to lock the person's medicines away had been taken in their best interests, whether any less restrictive option had been considered or who had been involved in this decision. We looked at another person's records where the agency were supporting a person's independence by helping them to do their own shopping. The person's care plan stated the person was limited by the agency as to certain products they could buy. The person did not have a mental capacity assessment and there were no records to show who had taken this decision and if it was in their best interests. We talked with staff about their understanding of the MCA. Some staff did not show a clear understanding of their responsibilities in relation to the Act, this included a newly employed member of staff. Other staff understood their responsibilities and said they had received training in the area.

The agency was not ensuring where people were not able to give consent that they were working within the Regulations of the MCA. This is a breach of Regulation 11 of the HSCA Regulations 2014.

At the last inspection, we found people were not protected because the provider had not ensured they always had suitably qualified, competent, skilled and experienced care workers deployed; who had received appropriate support, training and supervision as necessary to enable them to carry out their role. This included supporting people who had more complex medical conditions. We issued a Warning Notice in relation to this. The provider had met the Warning Notice.

We asked people about whether they thought staff were trained and supported so that they could meet their needs. We received positive responses. One person said, "Yes, they are properly trained," another "They know what they're doing," and another said staff were, "Definitely" trained. A person's relative told us, "They are trained in dementia, which is very useful with my relative. I know the carers keep up their training and do NVQs."

Staff confirmed they received the training and support they needed for their role. A care worker told us, "I think it equips you for the job," about training. A newly employed care worker told us, "The induction prepared me quite well." They said they particularly liked the way they were involved in the decision that they were ready to stop shadowing other care workers and start working on their own with people. In a questionnaire received by us before the inspection a member of staff wrote, "I would particularly like to commend the training that we receive regularly. It is absolutely outstanding." A care worker told us they were supported by training and an annual appraisal. They said they could bring things up during supervision and 'spot checks' when they felt they needed to.

In their PIR, the provider stated 'Our induction training will be extended to 3 days to incorporate more information on Dementia and medical conditions as we are currently bringing our training in-house and building a training team." The registered manager had clear training, supervision, appraisal and 'spot check' plans. We looked at these plans and saw a few of the plans were not fully up-to-date. When we discussed this with the registered manager, they knew the reasons in every case, for example where a member of staff was on long-term sick leave.

People told us they were supported appropriately by staff where they lived with medical conditions. A person told us, "I fell on the floor and couldn't get up, they called the paramedics and they looked after me well." Another person told us, "One time I had a migraine, they made sure I was all right. They also know they can use the alarm if needs be." All of the care workers were able to give us information on how they supported people who became unwell, giving us examples of when they had needed to do this in the past. A care worker told us they had been concerned about a person's changing medical condition and thought they needed more support. They told us this had been referred back to their funding authority and relevant medical supports requested.

The provider had started sending round information and fact sheets on medical conditions on a weekly basis, to inform staff of how to meet people's needs. A member of staff stated in their questionnaire, "Every week we receive new knowledge about a particular health condition that accompanies the weekly memorandum. I have found this incredibly helpful, "It helps me to keep up to date with different conditions." Another member of staff told us, "It is actually interesting to read them," meaning the fact sheets. Another member of staff said, "The fact sheets are good."

Where the agency supported people with their diet and nutrition, they were supported in the way they needed. A person told us they appreciated the way the care workers always ensured their relative had their lunch and wrote down what they had eaten. Care workers told us how they supported people, including by keeping records of food and fluids, where people were at risk. They showed a flexible approach to supporting people. One care worker told us about a person who varied in what they chose to drink and described how they always checked with the person what they wanted to drink each time they visited them.

Requires Improvement

Is the service caring?

Our findings

At the last inspection, We found improvements were required to ensure the agency provided a caring service. The provider had taken action to address a range of areas, however they had not identified and taken appropriate action in all areas. This was because they had not always ensured people's confidentiality. The provider sent information to care workers' personal phones, some of which could include people's personal information. They had not identified this as a risk to people's confidentiality. The provider had no policy and procedure in relation to staff conduct where it was necessary to send people's personal information to their personal phones, for example staff responsibility for password protection and deletion of information as soon as it was no longer needed. Such matters were not routinely followed up with staff, for example during their annual appraisals or supervision. This meant there was a risk to the confidentiality of people's personal information. Following the inspection, the provider told us they had taken action to introduce such a policy and that this would be kept under review.

When we spoke with staff about day to day confidentiality of people's personal information they were clear about their responsibilities. For example, a care worker told us if a person asked them about the condition of another person who they were also providing care to, they would politely say they could not give the information to them. Another care worker told us if this happened they changed the subject of the conversation, for example to a conversation about the weather.

People had sections in their care plans headed 'about me.' Some people's information was very limited and would not provide relevant information to a care worker who was unfamiliar with a person, particularly if the person had difficulties in communication. For example, one person's care plan stated they liked 'TV' and another's 'music' with no information on the types of television programmes or music they preferred. Another person's care plan stated they liked 'animals' with no further information, and another "read paper" with no information about what newspaper they preferred to read. This is an area which requires improvement to ensure all care workers had relevant information about people's individual preferences.

At the last inspection some people felt some staff were not caring in their approach and also the agency did not respect their wishes relating to gender of care workers for personal care. These areas had been addressed.

Everyone we spoke with said care workers were caring, respectful and polite in their approach. A person described care workers as, "Very nice people." Another person said staff were, "Polite and helpful," another person said care workers were, "Kind, polite and helpful - very good." A person's relative said they appreciated the way the care workers, "Respect Mum's wishes." A person told us care workers, "Had a gentle, respectful way." A person who told us they needed support to move around said, "The way they handle me is first class." A person said care workers were, "So gentle" when they supported them with personal care. A person described their relative as, "Feisty" and said despite that staff were, "Always polite" to their relative. One person told us although they had other issues with the agency and its management, "Each carer is always so kind and helpful."

People said they were always sent care workers of the gender they had requested. A person told us "I don't want a male and I don't get a male." A person told us "I always get a female helper as requested." The provider had added a trigger question on the preferred gender of care worker to their initial assessment form. An administrator confirmed they could put a 'flag' on the system, so they could ensure a person was not allocated a care worker of the gender they did not want for personal care.

People said staff respected them and supported their independence. A person told us the care workers, "Do what I want." A person said, "I'm a lot better for their help." A person's relative said the person, "Feels confident with them and they don't rush him." A person's relative told us the appreciated the way, "All the carers try to get him to talk, for example ask him 'what did you do this weekend' while supporting him." A person said, "They wash me, ask if I want anything, ask if I want to have a shower. They are so helpful." A person told us "Sometimes it had been quite a small thing that I just can't do and it makes a big difference." A person said they were impressed by the way the care workers "Get things done" and another said "They are meticulous in the way they do things."

People told us about their good rapport with the care workers. A person told us they thought the care workers they were sent had a, "Natural affinity" with them. A person said, "I get on well with them" about the care workers. A person told us, "They are chums, we laugh at silly things. If I've forgotten something when I am shopping they will go back and get it for me. It's like having a chum coming over." A person told us, "I have a laugh and a banter with them". A person described how a care worker had supported them in getting some things they needed saying, "They are a great bunch of girls."

Care workers knew people as individuals and showed a caring approach to people. A care worker told us when they talked with people they cared for, the people, "Open your eyes so to many different things in this world." A care worker told us about people who could refuse care at times. They said when this happened they needed to get to know the person as an individual and so find ways of supporting them, so they would accept the help they needed. Another care worker told us how they appreciated how hard it was for some people to ask for help. They said about older people who were used to living independently, "They have their pride." and so found it difficult to always accept the help they might need. They explained how important it was for them to be sensitive to such matters

In their PIR the provider stated, 'Our user feedback on our staff is excellent and they are hugely appreciated by our service users on their caring attitude and that "nothing is too much trouble for them".' In questionnaires sent out by the agency a person commented staff were, "Always friendly."

Inadequate

Is the service responsive?

Our findings

At the last inspection, we found the agency was providing an inadequate service in relation to being responsive to people. This was because the provider was not responding to people effectively in relation to timings of visits, informing people of changes to visit times and a lack of continuity of staff sent to them. We issued a Warning Notice under Regulation 17, requiring the agency to become compliant with the Notice by 30 April 2016. They had not met the Warning Notice.

We sent people questionnaires before the inspection. As at the last inspection, we received a wide range of comments about the timings of visits. In these questionnaires, 40% of the people who responded strongly disagreed with the statement that care workers arrived on time. People told us about the effect of this on them. One person wrote "One Sunday morning, arrived at 7:00am instead of 9:00am without warning." The person wrote they were "Still asleep and sent the carers away. Had to manage on our own that morning." When we spoke with people they also told us about their concerns and the effect on their lives of visits which were later or earlier than they had anticipated. A person told us "Care visits are frequently late and not timely for personal showers." Another person said they had, "Asked for no-one before 10am and they came at 7:30am – not suit my medical needs, means I'm dragged out of bed." A person told us they needed support to take their medicines, "And it worried me when they were 45 mins late"… "I ended up taking it myself." Such matters had also been reported by people in their reviews. A person's review for April 2016 which had been completed by the agency stated, "Time of the visit is too late."

Care workers also commented to us about visits in questionnaires sent to them before our inspection. One care worker wrote about, "Little or no travel time" between visits. When we spoke with care workers they confirmed this could be an issue. A care worker told us they were, "Always late" by end of the day because there was not enough time between calls. Another care worker told us there was a, "Silly amount of time to do half an hour's journey." A care worker told us the main thing which was needed to improve the agency was, "Improve travel time."

In their action plan the provider stated, 'Our care plans have been changed to record the client's desired time of visit.' We looked at the records of 10 people. None of them had this section completed on their records to either show their preferred visit time or about any records of discussion about this. One of the people who had recently been provided with a service told us how they had discussed the issue with the member of staff who had assessed them and had outlined their specific needs about visit timings, due to a medical condition. This information was not recorded on their assessment record. Records of this person's visit times for four days in August 2016 showed the information the person told us about had not been followed in relation to their visit times.

We looked the agency's own records about timing of visits for four days in August 2016. These showed for 624 visits over four days, 30% of visit arrival times were earlier or later by more than fifteen minutes from what was planned, 13% were half an hour earlier or later than planned and four per cent took place over an hour earlier or later than planned. These records showed there was no variance between week days and weekend days. We asked the provider if they had systems to identify and investigate visits which were

significantly earlier or later than planned. They said they did not have such a system. This was despite this matter being identified as an issue during the past two inspections.

People continued to report the agency did not inform them of changes to their rota and visit times. For example a person said, "They don't phone to tell me they are running late," another that they, "Never phone when they're going to be late" and another, "They are quite often late and I do think they could pick up a phone I tell you."

In their action plan the provider stated, 'We continue to reinforce the message to our staff that they must contact the office when running late. These calls are noted in our communication books as well as the calls to clients to inform them.' They stated this would be addressed by 30 June 2016. We asked staff if they informed the office when they were running very late. They confirmed they did this. We looked at the computer communication records for two of the people where they were recorded as having visits which were over an hour later than planned. Neither of them had documentation on their computerised records to show they had been informed of their late call time. The registered manager also gave us a separate handwritten record about communication with people. These also did not show these people had been contacted about their late visits.

As at the last inspection, people told us about their being sent a high number of different care workers, and the effect of this on them. In their action plan the provider stated, 'As we are no longer using agency staff, our clients are receiving more regular carers.' Some of the people we spoke with did not think this had improved since the last inspection. For example, a person told us, "There is quite a change over [of carers], I have had regular ones and lost them. I ask but they don't give you." A person told us about the effect of a high number of different care workers on their elderly relative. They said the person felt embarrassed by having so many care workers who they did not know providing personal care to them. We looked at this person's records, they received three visits a day they had 18 different care workers visiting them over 17 days. A different person had 12 visits over a four day period and was visited by 10 different care workers.

We asked staff about if they saw different people. We received mixed responses. For example one care worker told us, "I've got no regular clients," while another said, "I've got regular clients."

The provider continued not to ensure issues identified at previous inspections relating to visits to people and continuity of care had been acted upon. They had also not ensured that all relevant matters had been documented. This is a continued breach of Regulation 17 of the HSCA Regulations 2014

At the last inspection we found the provider did not ensure they had an effective and accessible system for identifying, receiving, recording, handling and responding to complaints from people and other persons. This was a breach of the Regulation. Following the inspection, the provider sent us an action plan in which they stated this matter would be addressed by 30 June 2016.

In questionnaire responses both to us and in the provider's own surveys, several people reported issues had not all been dealt with to their satisfaction, and also that some people did not feel comfortable in raising complaints. We also received mixed responses when we talked with people. A person told us, "You phone them up and they give you a range of excuses." A different person told us, "When you complain they say they are looking into it, but don't come back to you."

Some people's concerns and complaints were not documented, so managers were not able to take action to address them. A person gave us an example of a specific day when they rang the office to raise their concerns about changes in their visits. We looked at the person's computerised record. There was no record

made of this phone call. A different person's relative told us they had raised issues about the number of different care workers sent to their relative. There was no information in the person's computer record about this.

Some people said the agency had acted on the issues they had raised. One person's relative told us they had brought up an issue about a change in the care worker sent to their parent and the agency now sent the one they preferred. Another person told us, "Once or twice they have sent male carers I refused them and the agency has not sent them again." Neither of these issues had been documented as a complaint or a concern, so would not be available to managers to support quality reviews.

The provider had ensured some issues raised by people were documented. Complaints records showed three complaints had been received by the provider since last inspection. One related to a late visit time, one that the person had not been informed about a change in their rota and for one they were awaiting information from the person's social worker.

The provider had taken some action since the last inspection. However because not all issues were documented, or acted on, the provider continued not to have an effective and accessible system for identifying, receiving, recording, handling and responding to complaints from people and other persons. This is a continued breach of Regulation 16 of the HSCA Regulations 2014.

People said staff followed their care plans. A person told us "Yes, the carers follow it [the care plan] and everyday they look through it," another person told us "They follow the plan and review it." A person's relative told us "At the review they let mother talk and she signed her own review. I am pleased they involve her as much as possible." Care workers confirmed all people had an up to date care plan. A care worker told us "The care plan tells you all you need to know ." Another care worker told us they always took time to read a person's care file when they went into their home.

Inadequate

Is the service well-led?

Our findings

At the last inspection, we found the agency was providing an inadequate service in relation to being well-led. This was because they did not have effective systems to assess, monitor and improve the quality of the service and mitigate risk to people. The provider also did not maintain an accurate and complete record in respect of each person, staff, and management of the service. The provider did not effectively seek and act on feedback from relevant persons to evaluate and improve service provision. We issued the provider with a Warning Notice under Regulation 17 requiring them to have become compliant with the Notice by 30 April 2016. They had not met the Warning Notice.

People gave mixed responses about whether the service was well-led. One person told us, "Management as bad as it could possibly be," another person described management of the agency as, "Chaotic" and another person when asked said, "No I wouldn't recommend them." A person told us, "I don't know who the manager is, I'm not sure if there is a manager" and another person described the agency as, "Lazy." Several people said they would go to a different agency, but they were unable to do this because there were no other domiciliary care providers in the area where they lived. Such comments were not echoed by everyone we spoke with. One person told us about the agency, "They have been very good to me" and another, "I would say, they are absolutely perfect and I can't fault them."

Although the issue of visit timings and numbers of care workers sent to people had been raised at two previous inspections, the provider and registered manager continued not to have taken action to address this. They had information available which would enable review of such matters, but they had not used this information to audit if they had made improvements. The provider's statement of purpose continued not to outline their policy about timings of visits, as reported by the registered manager, so people were not informed about this when provided with a service. People had information in their contracts about actions they could take when they experienced late visits, but the contracts did not outline the provider's responsibilities. The lack of audit by the provider and registered manager meant they had not identified staff who assessed people's needs were not following their revised policies, by seeking and documenting information people gave them about relevant matters relating to visit times.

The lack of audit meant the provider and registered manager had not identified they were not following what they stated in their PIR. For example, although they stated in their PIR that all relevant risk assessments were in place, we found this was not the case, particularly in relation to risk of pressure damage. Because of the lack of audit they had not identified some people's risk assessments were not up to date and did not reflect what we were told. For example a person's risk assessment documented they were a 'heavy drinker,' which the assessment stated meant they had risk due to this alcohol intake. We asked the registered manager about this assessment. They said the person no longer presented a risk in this respect. The person's risk assessment was dated May 2016 but had not been updated to reflect this further information from the registered manager. The provider and registered manager had therefore not identified that If the person showed a change in their condition, any care worker who was unfamiliar with them would only have incorrect information, which could affect their perception of how to appropriately support the person.

As at the last inspection, the provider and registered manager continued not to perform audits of people's care plans to ensure they were accurate and up to date. For example they had not identified that people's care plans did not document relevant information about how to meet their needs. The registered manager showed us information on a person whose medicines were securely locked away in a box. The person's care plan did not document specific matters, which the registered manager told us about in relation to storage and management of the person's medicines. This meant care workers who were unfamiliar with the person would not have such information available to them.

The lack of systems for audit meant the provider and registered manager had not identified they were not following their own policies in other areas. For example, at the last inspection, we found among other areas, recruitment systems were not following the provider's own policies and procedures in relation to completion of their own documentation about the suitability of prospective new staff. In their action plan the provider stated 'Interview documentation is now being fully completed with the scoring being used.' We looked at three most recently completed interview assessments. Because the provider and registered manager were not performing audits, as at the last inspection, they had not identified that none of their own scoring sheets in their interview assessment documentation had been completed.

Because the provider and registered manager did not audit relevant areas, they did not develop action plans where relevant. Staff received regular supervision, spot checks and appraisals, and records were in place. The information in these records was not audited to ensure issues were addressed and action taken. For example one care worker's records documented they had found a certain person was becoming, 'very difficult at times.' The record did not clarify what was meant by the word 'difficult.' The care worker's file did not outline what support they needed, such as further training. There was no evidence on the care worker's file that this issue had been followed up, so the person or the member of staff were appropriately supported. Another care worker had stated that there was not enough travel time given between visits to people. There was no evidence on the care worker's file that this information had been considered further. We saw a staff supervision record which was incomplete. This had not been identified and action taken to ensure a full and accurate record.

Since the last inspection, the provider had introduced questionnaires which they had sent to people to receive feedback about the service. People we spoke with recalled being sent questionnaires, however some people also said they had not received any feedback from the provider about the outcomes of the survey. We looked at some of these questionnaires and also at the provider's overall review of responses. Some people had identified issues in their questionnaires and given their names. The registered manager reported they had responded to people when they did this and showed us an example of where they had done this. However, several people had completed questionnaires anonymously and the registered manager said they had not been able to follow up these issues due to this. Comments from some people related to a range of concerns, for example not wanting to raise issues with the office staff. Although the results of the questionnaires had been collated, the provider and registered manager had not developed an action plan from the range of such comments given by people. They had also not provided any feedback to people from the results of the questionnaires, to outline how and by when they would ensure improvement in service provision where issues had been identified.

The provider continued not to ensure people who used services were protected because they did not have systems, which operated effectively, to assess, monitor and improve the quality of the service and mitigate risk to people. The provider did not maintain an accurate and complete record in respect of each person, staff and management of the service. The provider did not effectively seek and act on feedback from relevant persons to evaluate and improve service provision. The provider did not improve practice, evaluating the information which they held about their service provision. This is a continued breach of

Regulation 17 of the HSCA 2014 Regulations.

We asked staff about the agency's philosophy of care and management systems. We received mixed comments from staff, some of which showed dissatisfaction and also a lack of confidence in communication and the management of the service. One member of staff told us in their questionnaire that, "The carers are all dedicated and very hard working, we cover vast areas with no breaks between shifts." A member of staff wrote that they were made to, "Feel guilty for saying no and god forbid we become ill and unable to work, it's Intimidating." Another care worker told us they did not know how the office set the timings of visits and the office would change timings of visits only if they were "Persistent." However, such comments were not echoed by other care workers. One care worker wrote in their questionnaire, "The service have made me feel a valued member of the team," another said, "This agency is one of the best" and another described the registered manager as, "Friendly and fair." A care worker told us, "I think it's great, if I had a relative that's ill, I would have this agency to look after without a doubt."

The provider and registered manager had taken some action, in certain areas since the last inspection, to improve the quality of the service. Three Warning Notices were issued following the last inspection. Two of them had been met. The Warning Notices which were met were in relation to ensuring safe systems for the recruitment of staff and ensuring all staff were suitably trained and supported in their roles.

In their PIR the provider reported on their philosophy and extensive experience and knowledge of the care industry by which they aimed to provide quality of care to people. Following this inspection the provider sent us detailed information about improvements they were making. This included policies relating to confidentiality, developments in risk assessments and action on ensuring the safety of medicines. They also reported on their findings from staff leaver surveys, stating they had identified themes in relation to a request for more travel time for the rural calls and sometimes feeling rushed during some calls. They reported there was 'much positive feedback about their colleagues, our clients and that they feel supported in their roles.' They said they would be including additional areas in the questionnaire to allow for better and easier tracking of reasons staff leave and this would be used to improve staff retention.

All of the care workers we spoke with were aware of the agency's lone working policy. They all said that if they needed to ring the on-call number, it was always responded to, so they felt safe when working alone.

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 11 HSCA RA Regulations 2014 Need for consent The provider was not ensuring that care was only provided with the consent of the relevant person. They were not ensuring that where a person was unable to give consent because they lack capacity to do so, they acted in accordance with the Mental Capacity Act 2005. This is a breach of Regulation 11 (1)(3) of the HSCA Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have effective systems to ensure care was provided to people in a safe way. This was because they were not consistently assessing risks to people's health and safety and doing all that was practicable to mitigate such risks. This is a continued breach of Regulation 12(1)(2)(a)(b)(g)(h) of the HSCA Regulations 2014

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not ensure they had an effective and accessible system for identifying, receiving, recording, handling and responding to complaints from people and other persons.

This is a continued breach of Regulation 16 (1) (2) of the HSCA Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who used services were not protected because the provider did not have systems, which operated effectively, to assess, monitor and improve the quality of the service and mitigate risk to people. The provider did not maintain an accurate and complete record in respect of each person, staff and management of the service. The provider did not act on feedback from relevant persons to evaluate and improve service provision. Regulation 17(1)(2)(a)(b)(c)(d)(i)(ii)(e)(f)