Kalcrest Care (Northern) Limited

Kalcrest Care (Northern) Limited

Inspection report

1 Eldon Place
Bradford
West Yorkshire
BD1 3AZ

Tel: 01274390552
Website: www.kalcrestcare.co.uk

Date of inspection visit:
24 October 2016
25 October 2016
26 October 2016
27 October 2016
28 October 2016

Date of publication:
14 December 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Kalcrest Care Limited is a home care provider offering personal care and support to people within their own homes and in their local community. The services provided include personal care, assistance with medication, cooking meals and daily activities. The agency is situated near the centre of Bradford but provides most of its care and support in the Kirklees and Leeds local authority areas.

The inspection took place between 24 and 28 October. We gave the provider a short amount of notice of our visit to ensure management staff were available to assist us with the inspection. At the time of the inspection there were 183 people using the service.

A registered manager was not in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Following the inspection the provider told us they had appointed a manager who would shortly begin the registered manager application process.

People and relatives provided mixed feedback about the quality of the service. Most people said they felt safe in the company of staff. They said staff were kind and compassionate and treated them in a respectful and kind manner. However most people told us timekeeping was poor and care needs were not met since staff didn't arrive on time or did not stay for the correct amount of time.

Medicines were not managed in a safe way. Medicines records were poorly completed which meant we could not confirm whether people had received their medicines as prescribed. There was insufficient information recorded on the medicines people were taking.

We found some people did not have complete care plans or risk assessments in place, which meant the risks to their health and safety had not been properly assessed. Some incidents and accidents were not properly recorded and preventative actions were not always noted to enable staff to learn from incidents.

There were insufficient staff deployed to ensure people received a reliable and consistent service at the times they needed care and support. Safe recruitment procedures were in place to make sure staff were of suitable character to work with vulnerable people.

Most people told us regular staff understood their needs and had the right skills and knowledge to care for them. However they said when staff had to cover shifts at short notice these staff did not know what to do. People said staff rushed and this was at the detriment to effective care, particularly for those living with dementia.

Overall we concluded, the service was compliant with the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards.

People's needs were not fully assessed and appropriate plans of care were not always in place. Some people were without complete care plans. There was a lack of information recorded on how staff should manage people's emotional and psychological needs and manage refusal of care and support.

Care was not appropriate, as staff were not consistently arriving on time or staying for the correct amount of time.

The service had received a large amount of complaints about the quality of the service. We saw many of these had yet to be properly processed. Complaint records showed themes first raised in early 2016 had yet to be fully resolved.

The provider and management were open and honest with us about the current challenges facing the organisation. They recognised the service required improving and were in the process of recruiting further staff to help enable improvements to the service.

We found a lack of systems and processes to adequately assess and monitor various aspects of the service. Some audits and checks were undertaken. However these were not sufficiently robust in resolving issues and were not always undertaken in a timely way.

We found care staff were not completing an accurate record in respect to each service user, with inaccurate visit times recorded on timesheets and people's daily records.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not managed in a safe way. Documentation was poorly completed and there was a lack of information on the medicines people were supported with.

There were insufficient staff deployed to ensure people received a consistent and reliable care service.

Risks to people's health and safety were not consistently assessed with a lack of robust risk assessments in place informing staff how to protect people from harm.

Is the service effective?

Inadequate

The service was not effective.

Staff training, supervision and checks on their skills and knowledge was not fully in place. People told us regular staff were good but other staff did not know what they were doing.

Staff were unable to stay with people for the full allocated time which was a barrier to effective care.

Care records did not demonstrate a full assessment of people's healthcare needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us staff were kind and treated them with a high level of dignity and respect. However people told us they were not informed if care staff were late or if they were going to have a different care staff member.

Some people told us they felt their comments were not listened to and acted on by the service.

Is the service responsive?

Inadequate

The service was not responsive.

Due to a lack of staff, appropriate and timely care was not delivered. Staff did not always arrive on time or stay for the required amount of time.

Care records did not demonstrate a full assessment of peoples' care and support needs.

Complaints were not appropriately managed as they had not been resolved or analysed in a timely manner.

Is the service well-led?

Inadequate

The service was not well led.

We identified several breaches of regulation and examples of poor service delivery which should have been prevented by robust systems of quality assurance and governance.

The checks, audits and systems in place were not sufficiently robust for a large domiciliary care service.

Systems to seek and act on people's feedback were not sufficiently robust.

Kalcrest Care (Northern) Limited

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 look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place between 24 and 28 October 2016. The inspection team consisted of three adult social care inspectors 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. On 25 October 2016 we visited the provider's office where we reviewed documentation and spoke with the provider, director and care co-ordinators. Between 24 and 28 October 2016 we made phone calls to people, their relatives and staff.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with 22 people who used the service, 12 relatives, 12 care workers, two care co-ordinators, the provider and a director. We looked at ten peoples' care records and other records which related to the management of the service such as training records and policies and procedures.

As part of our inspection planning we reviewed the information we held about the service. This included information from the provider, notifications and contacting the local authority safeguarding and commissioning team. We also spoke with two health and social care professionals who had liaised with the service.

Inadequate

Is the service safe?

Our findings

Most people told us they were happy with the way their medicines were handled by staff and staff practiced good hygiene. However people stated if staff were late this had an impact on medicine administration. For example, one person told us, "The carers put my eye drops in for me and cream on my legs. If they're late I try to put the eye drops in myself but it's not easy because I'm blind." Care staff we spoke with whilst acknowledging they were sometimes late, recognised the importance of ensuring time specific medicines were given at regular intervals throughout the day and said they prioritised these people to ensure their medicines were given at safe intervals. We saw if time specific medicines were required this was highlighted on care rotas to ensure staff were aware.

The service kept a record of missed medication detailing information and outcomes of any investigation. We saw one incorrectly given medicine had been documented in June 2016 with outcomes recorded. This included a supervision of staff to reduce the risk of a re-occurrence.

Medicines administration records (MARs) were in place. However those we reviewed were poorly completed and it was not clear what medicines had been prescribed or when they had to be administered. For example, one person's records care records showed district nurses applied a weekly pain patch yet the June and September MAR recorded the pain relief patch had been incorrectly signed by all staff as administered most days. Another person's MAR stated, 'Amoxycillin'. There was no start date, no information about dosage, whether this was a tablet or liquid or how often this medicine should be given. Another person was also prescribed a vitamin supplement; however there was no dosage or frequency recorded and only three doses had been signed as given in September 2016. We saw one person's statin tablet had been omitted for two concurrent days in April 2016 with no documented reason. Another person's antibiotic medicines had been discontinued with two tablets remaining. If the full course had not been completed the antibiotic treatment may not have been fully effective. There were a large amount of gaps on the MARs where there were no staff signatures to show medicines had been administered. This placed people at risk of harm as we could not be assured people were receiving their medicines as prescribed.

We were unable to find any up to date information in people's care records about what medicines they were receiving or why these medicines were being given. In one person's care plan the medicine risk assessment stated staff supported them with their medicines, but when we raised this with the care co-ordinator they said this was not accurate and needed amending. In other people's care records there was no additional information about medicines recorded on the MAR. This meant staff were potentially giving medicines and others planning care delivery without knowledge of the person's medicines, how they should be taken or the conditions they were intended to treat.

Some medicines were given 'as required' (PRN), such as topical creams and pain relief. However, we saw there was no specific information written on the MAR charts as to under what circumstances, how much and how these medicines were to be given. This contradicted the provider's PRN medicine policy.

Where topical creams were prescribed there were no body maps in place in the care records or indicators on

the MAR where these should be applied. MAR charts for topical creams were poorly completed. For example, one person's MAR showed they were prescribed two creams. There were gaps on the MARs where there were no staff signatures to show medicines had been administered. Another person had instructions written on the MAR for a cream to be applied four times daily since June 2016. However, we saw this had only been applied twice daily. This placed people at risk of harm as the provider could not demonstrate people were receiving their medicines as prescribed.

The provider told us they aimed to audit MARs monthly and would discuss any noted discrepancies with the member of staff involved. We saw audits had identified some issues such as information on the MARs not fully copied from information on the dossette box provided by the pharmacy. The provider told us and meeting minutes confirmed these had been discussed at team meetings and further training given. However we saw one person's MARs for June and July 2016 had been audited by the provider and they had identified issues in the recording of medicines. The record showed they had addressed these issues with staff in August 2016, yet we saw the same recording errors were made on the MARs in August and September 2016. Recent monthly audits had not always taken place due to a delay in the booklets being returned to the office or the provider's workload and other issues we found had not been identified through the medicines audit process. This demonstrated unsafe management of medicines.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was in the process of implementing new care plan documentation including new risk assessments. We reviewed some of these new assessments. However these were bulky, with a lot of generic information which could have been consolidated and made more person-centred. For example, one person's health risk assessment did not mention their ongoing medical conditions stating generic information only. In older care plans there were a range of formats of risk assessments in place. We concluded some of these were not detailed enough to provide staff with appropriate safety information. For example, one person had risk assessments in place for substance misuse and falls. The risk assessments were of poor quality and did not provide enough practical advice to control the risks nor had they been updated following a recent incident. A number of people who transferred from another care provider in May 2016 did not have any risk assessment documents in place including moving and handling assessments despite requiring two staff for transfers. This demonstrated risks to their health and safety had not been assessed and the outcomes recorded for staff. Some people commented staff did not have a good understanding of people and the risks they posed. For example, one relative told us, "One carer didn't know [relative] had problems swallowing and she had been feeding him for five weeks." This lack of understanding could have been avoided with robust care planning.

We reviewed the accident and incidents file and saw nine recorded incidents for the last year. The accident and incident form included information about the person and the situation. However, there was nowhere on the form to record the outcome, actions taken or lessons learned as a result. Some information about actions was written over the top of the form which was difficult to decipher. We concluded this was not a robust method of collating the data and auditing for prevention of future occurrences and to keep people safe. Some accidents/incidents had not been recorded in the accidents file. For instance, when we reviewed one person's daily records we saw they had been involved in an incident in August 2016 which had not been recorded in the accident book. The provider told us the forms were sometimes filed in the accident file and sometimes in the care records. This meant there was no central place for such information to be kept. We spoke with the provider about this who recognised a more organised system needed to be in place.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities 2014)

Regulations.

Most people we spoke with said they felt safe in the company of staff. One person told us, "They come in by using the key safe and they are very careful about making sure the house is secure when they leave me." Another person told us, "They are nice staff and I feel very safe with them." A third person told us, "I am very safe with the carers. They are very good, they help me dress and shower, I feel very safe and confident with them." A safeguarding policy was in place and we saw staff had been trained in safeguarding adults. Staff we spoke with were aware of how to identify and act on concerns. The service had notified the Care Quality Commission (CQC) of three safeguarding concerns in 2015 and one in 2016. However we saw information in people's records or from incident forms where CQC had not been informed of safeguarding concerns. For instance, we saw records of alleged physical abuse of a person using the service by their partner, and another regarding suspected financial abuse. We discussed these with the provider who told us they had been unsure if they should report these types of concerns to CQC but would do so in the future.

We reviewed financial transactional sheets for some people who use the service and found discrepancies. In two cases from April 2016 there were no receipts attached which meant there was not an accurate audit trail of financial transactions staff had carried out on behalf of people. We discussed these records with the co-ordinator who agreed that they did not provide clear records. This increased the risk of financial abuse particularly as these issues had not been identified by the provider.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

We reviewed the staffing rotas and concluded there were not currently enough staff deployed to sufficiently cover people's care and support needs. The provider agreed there were not enough staff at present. They told us they had taken over a large contract earlier in the year and many of the staff who they had taken on from the previous provider had either been dismissed or had left. In addition, there was not a registered manager in post and two care co-ordinator vacancies which placed additional pressure on office staff. We concluded from speaking with people, staff, reviewing complaints and rotas there were not enough care staff to ensure people received consistent calls at the times they needed them. Rotas showed little or no travel time was allocated between calls. In addition, where people had longer calls on certain days of the week for example for a shower, there was no additional time allocated for this. Staff also told us that in addition to the planned rotas, they often had to pick up additional calls each day. One staff member told us this was sometimes six and another told us up to ten extra calls. We saw on one date during our inspection a whole single run of 18 tea and evening calls had to be assigned to two staff already completing a busy evening and tea run. On reviewing the effect of this on time management, we concluded it was likely some people were receiving calls of less than half the agreed length. This was something some people and relatives told us they had experienced. Staff confirmed they couldn't stay the right amount of time when they were given additional work. One staff member said, "It's getting ridiculous, they ring with an extra 10 calls." One relative told us they had monitored call lengths and in total had calculated that their relative was only received 43% of their care package. Another relative told us that staff had sometimes only stayed for seven minutes instead of 45 minutes. A third relative told us, "It's frustrating more than anything. They are really nice with [my relative] and they do everything that's needed but they are definitely short staffed and that is the problem." Another person told us, "Those [care staff] are being worked to death. They are rushing around like headless chickens because they've got too many calls to make."

People and relatives said staff often arrived late with some people commenting staff arrived up to two hours after the allocated time. For example, one relative told us, "If they're late coming my [relative] will try to go to

the toilet but he doesn't know where he is so he ends up doing it in the chair. If they came on time in the morning they'd be able to get him to the toilet." Although we found the problems were mostly confined to the Kirklees area, staff who worked in the Leeds area also stated that this had a knock on effect as staff were being drafted in from there to cover the Kirklees area. The provider told us they had recently recruited 12 care workers with previous care experience who were currently going through the induction process and felt this would alleviate the staffing situation.

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

A small number of people told us calls had been missed, but overall we found people were receiving a service each day although calls were often reduced in length and/or late. We found one call had been missed recently due to a lack of communication and other people had cancelled calls themselves if care staff did not arrive at the agreed time.

Recruitment procedures were in place to ensure staff were suitable for the role and safe to work with vulnerable people. This included obtaining a Disclosure and Barring Service (DBS) check and at least two positive written references before staff commenced work. We reviewed eight staff files and saw correct procedures had been followed in all cases apart from one which the provider agreed to investigate.

People said the care staff always followed good hygiene procedures; they washed their hands, wore protective gloves and were smartly dressed in their uniforms.

Inadequate

Is the service effective?

Our findings

People provided mixed feedback about the quality of staff visiting their homes. Most people told us regular staff knew what they were doing and were well trained. For example, one person said, "They look after me really well," and a relative told us, "They have got to know him well; they know what mood he is in when they call." A third person said, "I think the carers all know what they're doing so I think they must be well trained." Staff we spoke with had a good understanding of their regular clients.

However other people told us that their care workers kept changing and there was a particularly problem with new staff that had not been in before. One person said, "They are very young and a lot of them have no idea how to make or change a bed. If the sheets are all ruckled up then it's uncomfortable and makes me feel sore." Another person said, "The [care staff] do well. They help me to wash and dress but there are too many different ones and then they don't have a clue what needs doing. Two came today who have never been round here before. It's not their fault. They have to try and sort out from the book what they're supposed to do." A third person said, "If it's the regular person everything runs well but if it's somebody else you never know who's coming or if they're going to be any good. Some are really poor; not all of them, just some."

We saw whilst attempts were made to assign rotas to the same members of staff to ensure consistency this was not always possible. Also, because of the significant shortfall in staff availability, staff were having to cover other rounds often at short notice, disrupting service provision and leading to a lack of continuity. One staff member told us, "Don't know some of these clients, going in blind." They said it was embarrassing to have to ask people or their relatives what had to be done at the call visit. Another staff member told us, "Dropping calls on us at short notice; knock on effect, only 30 minutes notice going to clients we don't know, we feel pressured into it." This demonstrated staff did not always have the correct knowledge to care effectively for people.

We reviewed staff training records and saw staff had received training in key areas such as first aid, dementia, health and safety, moving and handling, food hygiene, medicines administration, infection control and safeguarding adults. We saw dementia training had been provided to most staff. Some training was up to date but the
provider was aware other training needed to be refreshed and updated, particularly for staff who had transferred from another service provider who had not received any training or competency assessment since transferring. The provider did not have an up-to-date training matrix in place. Due to this it was difficult to see where
training had lapsed. We saw little evidence of specialist training such as epilepsy, diabetes or catheter care. However the manager told us a company had recently delivered 'sheath' training to a number of staff and another training company had been identified to deliver catheter care training.

During the inspection, the provider told us they were reinstating supervisions and appraisals since we saw many were out of date and those staff who had transferred from another service provider had not received any supervisions, spot checks or appraisals. They said they intended for supervisions/spot checks to be

carried out every eight weeks and appraisals every six months and were aware the new staff needed more support and supervision. However, due to the haphazard filing system, it was difficult to find up to date paperwork about supervisions and quality assurance checks. Following our inspection the provider clarified to us that staff supervisions in the Leeds area had been up-to-date and that supervisions and appraisal for Kirklees staff had begun the week of our inspection.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

We found the lack of continuity of staff and robust care plans had a particular impact on people with dementia and/or behaviours that challenge. People praised their regular care staff in managing behaviours. For example, one relative spoke of two staff who had developed a good rapport with their relative which enabled them to complete personal care tasks. However they also said other staff were unable to do this as they had not built up appropriate relationships. The person's care plan did not specify how to manage their behaviours that challenge. Another relative also told us staff were unable to appropriately manage their relatives behaviour. They told us, "They don't give (person) enough time when they talk to (person), they don't seem very well informed about dementia." We found they did not have a fully complete care plan in place to assist staff. One staff member we spoke with also told us they were concerned some staff were unable to build relationships and manage behaviours that challenge. We found there was a lack of information within care records demonstrating an assessment of people's emotional and psychological needs, how to meet them and manage refusals of care.

Care records showed involvement of district nurses, social worker and the moving and handling assessor. However, care records did not often include enough evidence that people's healthcare needs had been assessed; in particular those who had been transferred from another care provider in May 2016. For example, one person's care records stated, 'Person has ongoing health issue which doctors are aware of and regularly check,' however no further details were provided.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

People provided mixed feedback about staff at mealtimes. Most people said they were supported appropriately with eating or drinking, although we were concerned that short call times meant staff were rushing this aspect of care and support. People said regular care staff knew how to support them but not new ones. For example, one person told us, "The regular carers are brilliant. They know just how I like my potatoes. The only time I have a problem is when somebody else comes, especially the young ones. They can't even boil an egg. What's the point of employing somebody to do this type of work if they can't cook?" Care plans contained some information on the support people required with eating and drinking including the involvement of the family. Some care plans however did not contain much support information and there was a lack of information on people's likes and dislikes.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. In the case of Domiciliary Care, applications must be made to the Court of Protection. We found no people were currently subject to DoLS.

People told us they were able to make their own decisions and staff asked them what they wanted at each care and support visit. For example, one person told us, "If I don't feel like getting showered then they don't make me. They always ask what I want. I like that I can make my own decisions." Daily records of care demonstrated people were given choices and those choices respected. However there was a lack of evidence of strategies to deal with refusals of care and support. Staff we spoke with said they had received training in the Mental Capacity Act (MCA) and had an awareness of how to act within the legal framework. We reviewed care plans and found in some cases information about people's capacity to make decisions was stated within their plans of care but this was not universally the case. In one instance we found the care plan stated the person had dementia and didn't have capacity to make their own decisions, yet they had signed their support plan; there was no information about their capacity to understand their plan of care and the support they needed with this. We raised this with the provider to look into.

Requires Improvement

Is the service caring?

Our findings

Overall, people provided positive feedback about the attitude and nature of staff. They told us care staff were kind and compassionate. People said staff were respectful, polite and observed their rights and dignity. One person told us, "The carers are brilliant, they are very nice." Another person said, "The carers do their best, it's the office that needs to get its act together," and a third person said, "Overall I'm very happy. They come when they should and do what they need to do. They are good people." A fourth person said, "They are very gentle with me, they always tell me before they are going to move me, they say exactly what they are about to do." A relative told us how they were impressed about the person centred approach of their staff. They told us, "My carer had a birthday at the weekend and brought me some of her birthday cake." People said staff explained what they were going to do prior to care delivery and, "had a laugh" with them.

Some people told us of less positive interactions they had observed. For example, one person told us, "The company ring the carers while they are here, we could hear them swearing at the carer over the phone, it was terrible." We also saw some of the terminology used in daily records to describe people's behaviour was not always respectful of people.

People told us staff were often late and they were often not informed of this. One person told us, "They are short staffed. I'm supposed to have three calls and I'm always having to phone up to ask where my carer is. They're very nice when I phoned up and they send somebody but then they're very late." Another person said, "I never know who is coming or what time. I go to day-care on Thursday and Friday and sometimes I can't go because the carers haven't been and I'm not ready. They're supposed to help me get ready." A third person told us their visits were, "Booked for 7 o clock, but the office starts at 9 o clock so there is no-one to contact when they are late."

A number of people told us they had regular care staff who they were happy with. For example, one person told us, "We have regular staff in the week and other people at weekends and they are all really nice." People told us that whilst they built up positive relationships with their regular staff, due to staff shortages they also received staff they were unfamiliar with and were not informed of the change in personnel. One person told us, "On one occasion the manager called out to cover for carer, I didn't know who he was until I was told later that he was the manager; he didn't introduce himself." Staff we spoke with told us it was not always possible to inform people who was coming and if they were to be late, due to only finding out about extra calls themselves at short notice.

Staff we spoke with had a good understanding about the regular people they visited. In some cases, particularly where new care and support plans had been put in place, information about people's lives and life history had been obtained by the provider. This demonstrated staff had taken the time to learn about people to help the provision of person centred care. However this was not universally completed for a number of people without up-to-date care plans.

People we spoke with said staff helped them appropriately to maintain and develop their independence. New care plans contained information on people's goals and aspirations, although a number of people did

not have information stating how staff were to support them to maintain independence.

Some people told us they felt listened to by staff, but others said they did not. We found there were a high level of complaints, many of which had not been properly actioned with reoccurring themes of staff lateness and not staying the correct time. We saw some care reviews were overdue and people had not always received formal check-ups/review in line with the providers stated policy. One relative told us their family member's care plan had not been reviewed since commencement of the contract 2 years ago. Another person told us they had complained about a care worker, and did not want them back. However the staff member was sent again which had caused them some distress. We raised this with the provider who told us this had been an error due to a breakdown in communication.

Inadequate

Is the service responsive?

Our findings

People and relatives provided mixed feedback about the overall quality of care. A number of people said their care needs were met by the service. For example, one person told us, "The carers do all the things I ask them to do, they are very good." Another person told us, "I'm very happy. I tell them what I need and they ask me as well. This is the best company I've ever had. I asked for an early call and they are always here between 6.30 and 7am. It's usually the same person unless he's on holiday and I'm very fond of her." A third person told us, "They have been amazing. I had an accident which meant I couldn't do the things I was doing, like the shopping for example. I was really worried but they stepped in straight away and have really helped out."

However other people said care staff were too rushed to undertake some tasks such as cleaning teeth or ensuring creams were consistently applied. We found appropriate care was not consistently delivered as staff did not always arrive on time or stay for the correct amount of time. Most people and relatives (24 out of 34) said that timekeeping was poor and staff didn't arrive on time and/or stay for the correct amount of time. There were no details of the call times which had been agreed with people within their care records for staff to adhere to. One relative told us, "We were never given a guidance time. Morning call can occur anytime between 07.30 and 10.00." A person told us, "On paper they should arrive at 08.30 but they never get here before 10.30. I just have a lie in until they come." A second person told us, "I get upset when they are late on Thursday and Friday mornings because I should go to day-care. Sometimes I can't go because they haven't been and I'm not ready. I thought they were starting to do better but they keep missing me." Daily records we reviewed showed the person's morning call had ranged from 6.30am to 10am and although it was stated that the person went to day-care in their care records there were no details of how call times should be planned around this. Another relative told us, "Call times are getting to be more and more erratic. The first call for the last few days has not been until about 10.30am and then [my relative] will have gone to the toilet in the chair because he can't wait." A review of this person's care records showed they had received some late and inconsistently timed calls. Another person told us, "They're supposed to be here at 9-9.30am and they've not been arriving until 10.45am. That's nearly dinnertime." We could not review the times this person had received calls as records had not been brought back to the office in a timely way. However the rota showed they were scheduled for a 10.20am call but with eight calls beforehand and no travel time allocated between any of these calls. This meant staff would struggle to arrive at the scheduled time. Some staff told us they did not always follow the order on rotas as it made more sense geographically to do it their own way. One staff member told us, "Person is on the rota for 6am, but they don't want a call until around 9am, so we don't follow the time on the rota." A culture of individual staff deciding the order of calls had contributed to inconsistency in call times.

On reviewing rotas and speaking with staff we concluded the service was unable to meet people's needs due to poorly planned rotas and staff picking up extra calls. Where people had extra needs in calls on particular days of the week, such as for assistance with showering, no additional time was allocated on the rotas. On reviewing rotas across the whole area of service delivery we found a large number of calls stacked together with no travel time between calls. This meant people could not be seen on time and staff could not stay for the correct amount of time. Whilst we found the problems were most widespread in the Kirklees

area, the Leeds area was also affected since staff told us Leeds staff were being allocated to cover the Kirklees area. One relative told us they had serious concerns about how short calls were, for example stating that carers had only stayed seven minutes instead of 45. Staff on this run told us on occasions they had to pick up additional calls from other runs which meant they could not stay the full amount of time. For example, we saw two staff on this run had to pick up 18 additional calls between them on 26 October 2016 which meant it highly unlikely they could stay anywhere near the agreed time. Another relative told us care staff were consistently not staying for the full allocated amount of time. They told us they had monitored call lengths and had received less than half the contracted call package; for example, with call times of nine minutes instead of 30 minutes.

Although we found some daily records showed staff arrived at a consistent time, four people told us staff did not write the correct times on the daily records particularly in regards to the call length. We also saw a number of complaints had been received which stated this was the case. This led us to conclude the real situation was worse than records suggested. We uncovered some evidence of false record keeping when reviewing timesheets and daily records. For example, we saw one care staff had written they had attended two different addresses for the same 30 minute period.

The provider told us they were in the process of implementing new care documentation which was more person-centred. We reviewed a variety of care records, some of which had the new style records in place. However we found shortfalls in the records we reviewed. Some care records did not reflect the calls or the care people were receiving. For example, one person's support plan showed they had one call a week, however other records showed since August 2016 the person had been receiving two calls every day. The support plan had not been updated and did not reflect the care and support the person required from staff. There was no care plan or daily records available in the office for one person who had been receiving a service since February 2016 and as such we were unable to check whether they received the required care and support. Two other people who had transferred across from another care provider in May 2016 only had a basis assessment of need with a lack of thorough assessment of the tasks required at each visit. We found another person only had a draft care plan in place which was not fully completed despite using the service since May 2016. We spoke with the person's relative who said that staff did not understand how to care for their relative and did not complete all tasks; for example, ensuring their relative's teeth were brushed. We saw some people's assessments showed they were living with dementia and sometimes displayed behaviours that challenge towards staff when they were providing personal care. However, we saw there was no information in the support plans to guide staff in how to manage these situations.

People were required to have their plans of care reviewed after six weeks, six months and annually thereafter. We reviewed records and saw some care plans were up-to-date but others had not been reviewed within the required timeframes.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

Daily records were in place for people that used the service. However we found a number of gaps where no details of the call were recorded. Timesheets suggested the calls had taken place, but we could not confirm this due to the lack of appropriate records kept with regards to the care and support people had received at these visits.

This was a breach of regulation 17 of the Health and Social Care Act 2008 Regulated Activities 2014 Regulations.

We looked at the complaints file and saw nine complaints had been recorded since February 2016. Seven of the complaints had been raised by people through Kirklees Local Authority, one through Leeds Local Authority and the other directly with the provider. It was not clear form the records we reviewed if the issues raised had been dealt with and resolved to the complainant's satisfaction. The complaints raised mainly related to the timing and duration of calls and the accuracy of records made by staff in relation to these. In addition, the provider also showed us a substantial pile of records which included a large number of complaints they said they had received but not yet had time to go through. For example one person told us, "Kalcrest have not taken this complaint seriously enough and have not deemed it severe enough to put immediate improvements in place as I would have expected. Especially when it involves the health and wellbeing of an elderly lady with dementia." Another person said, "They didn't seem very interested in the meeting when we complained." We found many of these issues with timeliness and record keeping had not been fully resolved despite some being raised as early as February 2016. The volume of complaints and lack of management resources available meant it was hard to process, analyse and learn from complaints in a meaningful way.

This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations.

Inadequate

Is the service well-led?

Our findings

People provided mixed feedback about the overall quality of the service. For example, one person told us, "I am quite happy with how things are going." Some people said they felt the service was disorganised and most people said they believed the service was very short staffed and care staff were working excessive hours. One person told us, "The service is rubbish. They're working those [care staff] to death. They are always adding on extra calls and they tell us that they end up doing sixteen hours in a day. Well nobody can work properly if they're tired." People said the service felt overwhelmed and senior staff were having to come out to cover calls. One person told us, "They need to recruit the right amount of carers, they are losing the quality of our care." People said they had been told new staff were starting soon which would help alleviate the problems experienced.

A registered manager was not in place. The last manager deregistered in July 2016. Following the inspection the provider told us a manager had been recruited who would begin the application process to become the registered manager for the service. We found there was a shortfall of management resources available to lead the organisation. As well as being without a registered manager, there were two care co-ordinator vacancies. This had resulted in delays with many management tasks; for example, processing and filing complaints, maintaining accurate records such as the training matrix, undertaking timely supervision, spot checks, care reviews, audits and service checks.

The provider told us the service had grown considerably due to the taking over of another service provision and that they felt this had had a detrimental effect on the quality of the service. However they told us they and their team were committed to service improvement. During the inspection we saw the management team responded positively to our comments and maintained an open and honest attitude. The provider told us, "We're passionate about what we do." When discussing staffing shortages and how staff have responded they praised the staff and said, "We owe staff (gratitude).They've been absolute stars." The provider said the office staff had worked hard to sustain the service and said, "The office co-ordinators have helped me keep it going."

Some people told us they felt unable to trust the company as they had seen records falsified such as the time that care workers arrived at their relative's houses. We found this was prevalent from reviewing records, speaking with people, staff and reviewing complaints. In some cases staff had failed to correctly fill out some timesheets with the times they had attended calls. In other cases, times written in timesheets contradicted the time written in the daily records of care or in other timesheets. Daily records often claimed staff had always stayed the full amount of time to the exact minute which contradicted people's feedback. One staff member confirmed to us, "Some staff won't write how long been in place, only the amount of time they should have been in." This meant a complete and accurate record was not maintained in respect to each service user.

Systems to assess, monitor and improve the service were not sufficiently robust. The service should have operated in such a way to prevent the breaches in regulation we identified from occurring in the first place, through the operation of robust governance and management systems. Care plan documentation was not

consistently in place with some people being without care and support plans despite using the service since May 2016. Sufficient training, support and monitoring had not been provided to staff, particularly new staff transferred over from another care provider in May 2016. Medicines were not managed in an appropriate or safe way and people were not receiving calls at the times that they needed them.

Some audits of care records took place. However, although these were supposed to be completed at the end of each month, the service was behind in the reviewing of these. In addition, care records were not always brought back to the office in a prompt manner. This meant key areas such as care records and medicines records had not been properly reviewed. We found issues identified earlier in 2016, such as with medication documentation, had still not been resolved. Systems to undertake spot checks and ensure care reviews were managed in a timely way were not in place. Complaints and accidents were not analysed and audited to identify themes or trends. Although people's views had been sought on the quality of the service, there was no structured approach to this and no central collation of feedback to inform the quality assurance process.

Staff and management meetings were periodically held. We saw a number of the concerns we identified during our inspection had been identified by the provider although we saw no evidence these issues had been resolved. The provider told us once new staff were recruited and the management posts filled, they hoped the service would run more smoothly and the remaining quality issues addressed.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 regulations.