Wii Care Limited

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Inspection report

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13 September 2016

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 12 and 13 September 2016. The inspection was unannounced.

We carried out an announced comprehensive inspection of this service on 16 January 2015. After that inspection we received concerns in relation to; staff not getting paid on time, staff not turning up, staff turning up too late or too early, people consistently not receiving the amount of support time allocated to them and poor moving and handling techniques. We reported these concerns to the local authority. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Wii Care Limited on our website at www.cqc.org.uk

At the time of the previous inspection the service delivered personal care to 20 people.

Wii Care Limited was registered to provide personal care services to people living in their own homes, mainly in the Medway, Dartford, Swanley and Gravesend areas. There was an office base in Rochester in Kent. At the time of our inspection there were 158 people receiving a service.

There was a registered manager based at the service who was also the registered provider. 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.

All the people we spoke with were not happy with the service provided. They said staff often arrived either too late or too early which meant they were sometimes turned away. Often staff did not turn up at all and when people rang the office to report this they did not get the help they needed. The staff did not spend the full amount of time people were assessed as needing. Most of the people we spoke with told us they did not have the same staff each time so their care was not consistent.

The registered provider did not have sufficient staff to provide the personal care that people were assessed as needing. The records we looked at, including staff rotas and timesheets showed that staff often had more visits than they had time to do in the time allocated. Rotas were inaccurate. Frequently more than one person had been allocated the same support time with the same staff member. Most of the time staff had two or three visits to make at 07:30 or 08:00. This meant that they were running late for all of their care visits from the very beginning of the day.

Staff did not have any break times allocated into their rota for the day. Travelling time between people's homes was not allocated on the rota. This meant that staff did not have an opportunity to take a break through the day as they were always catching up on time.

People were placed in a vulnerable situation by not receiving the care and support they had been assessed as needing. Staff rotas showed that staff often started their first care and support visit far earlier than had been planned on their rota. People had not received their care and support at the times allocated or agreed with them which meant their needs and preferences were not met.

Individual risks were not identified and assessed to make sure staff provided the most appropriate and safe care to people in their homes. Environmental risks inside and outside the property had been suitably assessed to help to keep staff safe when visiting people's home's.

Recruitment policies were in place that had been followed. Safe recruitment practices included background and criminal records checks prior to staff starting work. Staff were not recruited until they had been through a selection process that ensured they were suitable to work with people.

The registered provider did not have measures in place to ensure the safe administration of medicines to people in their homes. Guidance was not available to staff when administering people's prescribed medicines. Information describing the potential side effects of people's medicines was not evident. Instructions when to give 'as and when necessary' (PRN) medicines were not in place to give advice and guidance to staff when administering these medicines.

There was no clear and robust system in place to deal with complaints. Some people told us they had made complaints and because they had not had a satisfactory response they didn't raise other complaints. Some people were responded to and others were not. There was no quality assurance by the registered provider to make sure complaints were logged and responded to appropriately. No systems were in place to check trends or to be able to learn from complaints made in order to improve the service.

Staff were dissatisfied as their monthly pay had been late on a number of occasions.

Monitoring and auditing systems were not in place to check the quality and safety of the service provided. The registered provider had introduced two quality assurance systems to check care plans and to check medicines administration. However these had not been effective as no issues had been picked up and no action planning was in place to rectify problems found.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the registered provider to take at the back of the full version of the report.

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

The 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.

The provider had not deployed enough staff to provide assessed care and support.

The rota was not effective to ensure people received the support they needed and wanted.

Individual risks were not always identified to ensure measures were put in place to keep people safe.

The information required to help keep people safe when staff were administering medicines was not always available.

Safe and robust recruitment records were kept to make sure the staff employed were suitable to support people.

Is the service well-led?

Inadequate

The service was not well led.

Systems were not in place to ensure staff got paid on time.

People's feedback had not always been captured, recorded and responded to. There were no methods to accurately record and learn from accidents, incidents or complaints.

Records were not accurate or complete.

Appropriate systems and processes were not in place to audit, monitor and improve the quality and safety of the service provided, including seeking and acting on the views of people and relatives using the service.

Wii Care 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 check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook an unannounced focused inspection of Wii Care Limited on 12 and 13 September 2016. This Inspection was undertaken in response to concerns raised with CQC in relation to; staff not getting paid on time, staff not turning up, staff turning up too late or too early, people consistently not receiving the amount of support time allocated to them and poor moving and handling techniques.

The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well led? The inspection was undertaken by two inspectors on 12 September 2016 and one inspector on 13 September 2016. A third inspector made telephone calls to people and their relatives after the inspection.

During our inspection we spoke with eight people who received personal care from the service and three relatives to gain their views and experience of the service provided. We also spoke to the registered provider, the deputy manager, two care coordinators, the assessor, the in house trainer and seven care staff. We gained feedback from two health and social care professionals.

We looked at ten people's care files and six staff records, the staff rota and team meeting minutes. We spent time looking at records including policies and procedures, complaints, incident and accident recording systems and medicine administration records

Inadequate

Is the service safe?

Our findings

Most people told us they had different staff each time they had a support visit. People said they were not happy with this. One person told us, "I have all different girls visit me, it is awful because I have three calls a day". Another person said, "I have all different staff, I never know who it will be until they get to the door. I have two staff every visit". We were told by another person, "I have the same now most of the time, but I did keep complaining and the owner came here in the end. It has now improved. I have four calls per day, with two staff each visit, that is a lot of different staff in just one day so it was terrible. I have asked time and time again for a rota so we know who is coming but they never send one".
Relatives were not happy with the lack of consistency of staffing for their loved ones. One relative told us, "Because of times they [Wii Care] were visiting we have taken over the caring as a family. It was all different staff coming and the times were all over the place".

The registered provider did not have sufficient staff to provide the personal care that people were assessed as needing. We looked at a number of staff rota's that showed staff had too many visits a day to cover. In some cases the amount of visits booked on the staff member's rota would not be possible to deliver. All the staff rota's showed that they had not been allocated time for travelling between visits. For example, the first visit may be 07:30 to 08:00, the next visit was 08:00 to 08:30 and the next visit 08:30 to 09:00 and so on throughout the day. We also found that more than one visit was allocated the same time slot on one staff member's rota. For example, one person was allocated 06:45 to 07:15 and two other people were allocated 07:00 to 07:45. No breaks were allocated on the rota for staff. On 25 August 2016 one member of staff had been allocated 34 care visits on their rota, on 30 August 2016 they had been allocated 37 care visits, on 31 August 2016 they had been allocated 41 care visits and on 08 September 2016 they had been allocated 35 care visits. The planned working hours for these four days started at 07:00 and ended at 21:30. Some people were allocated one hour care visits, some 45 minute care visits and the rest were 30 minutes. The staff member could not have visited that amount of people within the 14.5 hours they had been rota'd to work, even without a break and without travelling in between people's homes. Many other staff members had similar rotas with far more visits than they would have been able to cover in the times allocated.

People told us they did not receive the full amount of time for their support that they were allocated. One person said, "They are rarely here as long as they should, although a couple of good girls get near it". A relative told us, "On [date] a carer came, I was in the garden for a few minutes, when I came back in my family member said they have been, I looked in the book they had signed in and signed out 30 minutes later, however they were there just 4 minutes".

We looked closely at staff timesheets from the previous two weeks, where the actual times visited by staff were recorded. Staff logged in to a visit when arriving at people's home's using their mobile phone and logged out again when leaving. The majority of staff timesheets showed actual visit times logged by staff as far less than the times allocated and that people were assessed as requiring. One staff member's time sheet for 05 September 2016 showed out of nine visits made in the evening, one person received 11 minutes over their allocated time and all eight other people received less than the time they should have been given. One person who required a 30 minute visit received ten minutes, another received 13 minutes and another 15

minutes. Another staff member's timesheet showed on 07 September 2016 that out of the 20 visits made, three people received their allocated support time and all 17 other people did not. Eight people who should have received 30 minutes care had ten minutes or less, seven people received less than 20 minutes instead of 30 minutes and one person received 22 minutes instead of 30 minutes. The last person should have received 45 minutes and received 35 minutes. This was a common picture across all the rota's and timesheets we looked at. We looked at the timesheet for one staff member on 8 September 2016 who had 35 visits on their rota for that date. They completed 33 visits according to the timesheet. However, the logging in and out system appeared to be flawed as the staff member was logging actual times visited but there was no time separating one visit from the next. For example, the first visit was logged as 07:25 to 07:48, the second visit was logged as 07:48 to 08:31 and the third as 08:31 to 09:13. This would not be possible even if people lived next door to each other. Although there were many more visits on the staff member's rota, no actual visits were logged after 14:41.

We looked at four invoices sent out for payment for people's support. The invoices showed that payment requested each time was for the full assessed and allocated times, not for the actual times received. We reported this to local authority commissioners.

The provider had failed to deploy sufficient staff numbers. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

People were not receiving the care and support they had been assessed as needing. People told us they often had missed care visits. They gave us examples of when no staff had turned up and when staff had been too early or too late which resulted in people cancelling their care visit. One person said, "We often have missed calls over the last 3 months, some days no one at all comes. The agency has no plan how they are going to cover so many calls. One girl who came was in such a rush and I reminded her that I should have at least 30 minutes, in fact it is meant to be 45 minutes in the morning, she said she can't stay that long she has 25 calls to fit in". Another person told us that on "[Date] they didn't show up for the afternoon call. [On date] they were supposed to be here 08:30 to 08:45 and they showed up at 09:10 then they left at 09:40 for what was supposed to be a one and a half hour call".

A missed care visit log was kept in the office. The log had very few missed calls recorded; four over two days in May 2016 and two over two days in June 2016. Three of those recorded reasons why the care visit was missed as 'carer late', two recorded 'unknown' and the sixth was blank. There was no reported action taken and it was not documented who had reported the missed care visit. No missed calls had been recorded since 11 June 2016 on the missed calls log. This was despite five people we spoke to in August 2016 and September 2016 saying they had missed calls in recent weeks. Concerns were also raised by people that staff were arriving so late or so early that they were turned away. These had not been recorded as missed calls on the records we looked at. A member of staff said, "Some clients get upset when their calls are not met on time. I don't think calls are being missed but there are plenty of refused calls where people are so late that people say don't bother". This meant that people's assessed needs were not met. At other times, staff provided only a small part of the time allocated which meant people did not receive the support they needed or in the way they had agreed. Staff timesheets showed that staff actually started their working day before the times allocated on their rota. For example on 25 August 2016 one member of staff started their first care and support visit at 06.45 when that person's visit had been planned on the rota for 08.30. On the 26 August 2016 the same staff member started their first care and support visit at 05.57 when that person's visit had been planned on the rota for 07.00. People often did not receive the care and support they had been assessed as requiring or they had agreed to as the registered provider had not planned their care appropriately which left them in a vulnerable situation.

The provider had failed to provide care and support which met people's needs and preferences. This was a breach of Regulation 9(1)(a)(b)(c)(3)(b) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

The provider had not assessed and mitigated risks to ensure care was delivered in a safe way. Each person had a control of infection risk assessment and a control of substances hazardous to health (COSHH) risk assessment. These were generic assessments that were not person centred to meet each person's needs. Individual risks to people when providing personal care within their home were basic in some instances and had not been identified at all in others. For example, there were no moving and handling risk assessments in place for people who required support to move around their home, requiring two staff to help them and using equipment such as a hoist. One person's risk assessment stated, 'use the hoist to transfer safely'. There was no step by step guidance for staff to safely support the person in their hoist. Therefore staff did not have information and guidance to safely work with people and use equipment. This meant people and staff were at risk of harm. One person who was diabetic had a risk assessment that identified they were at risk of developing pressure sores on their feet. The risk assessment did not detail what staff should be doing to reduce the risks of developing pressures areas. The risk assessment detailed 'if concerned contact the office'. The risk assessments that were in place were not robust and did not identify individual risks to guide staff how to keep individual people safe.

The response to accidents and incidents was not consistent. Staff did not always report situations that should be classed as an incident. For example, we saw in one person's daily log where staff had recorded the person, 'shouted while moving, not happy with the way we hoisted'. There was no further recording of why the person shouted and was not happy. We spoke to a care coordinator about this who told us that the person often did this with new staff. They said that staff got to know this. No individual moving and handling risk assessment was in place to give specific guidance to staff how to support the person in the way they preferred. Another incident was recorded in a person's daily records by a member of staff stated, 'carer walked out'. No incident report was made and no further details were recorded, for example if the incident had been reported to the office. We spoke to the coordinator about this who confirmed there was no incident report and the incident had happened. Accidents and incidents were not reviewed in order to learn lessons and to improve the safety of the service provided accordingly.

The provider had failed to ensure that care was delivered in a safe way. This was a breach of Regulation 12(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

People were at risk of harm as the registered provider did not have measures in place to ensure the safe administration of medicines to people in their homes. Guidance was not available for staff when administering people's medicines. One person's risk assessment for medicines administration stated, 'any side effects to be reported to the office or on call immediately'. The document did not detail what the side effects were for the medicines the person was prescribed. Some of the person's prescribed medicines were to be given 'as and when necessary' (PRN). No protocols were in place to guide staff why the medicine was prescribed or when to offer the medicine. This meant that the person was at risk of not receiving the medicine when they required it. We spoke to the coordinators about the lack of guidance around side effects of medicines and PRN medicines. They told us there was no further documentation. They said if people were sick or nauseous staff would contact the office as these would be the usual side effects. They also said most staff knew people well so would know if something was wrong. We asked what would happen if new staff who did not know people well were supporting people or if people suffered side effects other than nausea or sickness. Side effects that were specific to the medicine prescribed. The coordinators agreed that this was not clear. The provider had failed to ensure that medicines were managed properly.

The provider had failed to provide the information necessary to ensure medicines were administered safely. This was a breach of Regulation 12(g) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Environmental risk assessments of people's homes were undertaken to identify any risks to staff when attending the property. The outside of the property was checked for hazards such as poor street lighting, driveways, or outside steps. The inside of the property was looked at for the whereabouts of fuse boxes, water stop cocks and smoke alarms. Equipment in the home such as hoists were checked during the initial assessment to make sure they had been serviced and were in good working order.

The registered provider's staff recruitment practices ensured that staff were suitable to work with people in their own homes. Checks had been made against the disclosure and barring service (DBS) records. This highlighted any issues there may be about staff having criminal convictions or if they were barred from working with vulnerable people. Application forms were completed by potential new staff which included a full employment history. The registered manager made sure that references were checked before new staff could commence employment.

Inadequate

Is the service well-led?

Our findings

People told us they did not always get a satisfactory response when they contacted the office at Wii Care Limited. One person said, "I have rung but they are not helpful". Another person told us, "I only ring the office to find out where someone is if they are very late. They tell you they will find out by ringing the staff who should be with you to find out what the problem is. They don't always ring straight back though".

The registered provider told us that if any concerns were raised by people they would personally go out to visit them to find out what the problem was. Some people said the registered provider had been to see them when they complained. However, there was no consistent approach to complaints and complaints were not always captured or recorded by office staff. We were told by many people they had made a complaint and had heard nothing further. One person said, "They never bother to come back to you if you complain, they take no notice. I tell them about missed calls, what's the point, they don't care". Another person told us, "When we complain it goes no further than the person taking the call". Relatives also shared their frustrations about not getting a response in a timely manner when they had complained. The provider had not taken action to address people's concerns. There was no system in place to ensure that lessons were learnt from complaints to prevent the same issues happening again and no action had been taken to improve the service provided to people.

The registered provider had failed to establish and operate a suitable system to identify, receive, record, handle and respond to complaints. This was a breach of Regulation 16 (1)(2) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Staff did not feel supported by the registered provider and they told us this was affecting staff morale. We received calls from staff who were unhappy because their salary had been paid late on more than one occasion. Staff said they had received correspondence from the registered provider to apologise about this. One member of staff told us, "We are getting letters every month. People are having to change their rent days. Landlords are getting annoyed. We've got kids, and we're being messed about". Another member of staff said, "It is very stressful. The pay date has been changed many times. I've been unable to pay bills and I have to keep changing dates with the mortgage company". The registered provider told us there had been many unhappy staff mainly for two reasons. They said that some staff had transferred from a different provider when people's care was taken over by Wii Care Limited. Some of those staff were not happy to transfer and some had since left. The registered provider also told us that some staff had been unhappy because there had been delays with staff pay due to invoices being slow to be paid to Wii Care Limited. The provider did not have suitable systems and processes in place to ensure staff were paid on time.

Staff did not feel supported by the registered provider to carry out their roles. Staff said they had too many calls to make and many staff had left because of the many issues. A member of staff said, "We don't get breaks as the break time we have is used to catch up on the calls we are running late for". Another member of staff told us, "The trouble is that driving is not taken into account. We have calls booked for 07:00 to 07:30 then 07:30 to 08:00 so you are never going to get there on time with the distance you have to drive to get to the calls". Staff meetings were not taking place regularly. The only one recorded took place in April 2016

when medicines administration had been discussed regarding correct recording of medicines administration records (MAR), training and auditing. However there was no record of which staff attended and no actual date on the meeting minutes. In a meeting in July 2016 the registered provider discussed the issues with payroll and the late salary payments with staff. The record of the meeting was limited with only an agenda, no minutes and no attendance sheet to show which staff had attended. There was little opportunity for staff to raise concerns or for the registered provider to attempt to raise staff morale and to be assured of the well-being of his staff. Lack of staff support and low staff morale added to our concerns around the safe management of the service.

Questionnaires that required completion by people or their relatives were kept in people's care files. The aim was to complete these with people during their care plan review. However, many of these had not been completed. We counted 58 that had been completed out of 150, which is just over a third of people. This meant that people did not have the opportunity to give their views of the service and care and support they received. There was no process to gain feedback in a formal and planned way to be able to use the information provided to check the quality of the service. The results of the questionnaires that were completed were not analysed in order to improve the service provision. The registered provider told us that they visited those people who raised negative comments, however there were no written records of these visits.

The registered provider told us they had commissioned an independent organisation to undertake a comprehensive audit. However, they did not have a copy of this audit so we were not able to see it or find out the date the audit had been undertaken. They told us the deputy manager had taken notes at the time and developed an action plan based on these notes. Although we saw these notes there was no audit to show what the action plan was based on. It was therefore unclear if all actions required had been included in the action plan. An audit of care files had been carried out on 29 August 2016 by the deputy manager and a care coordinator. No previous audits had taken place. The audit checked that the correct paperwork was within the file. Where items were missing, actions were not recorded with the date and person responsible for rectifying the problem. There were no records to show evidence of when actions were completed. For example, the audit was clear that only 58 out of 150 customer feedback forms had been completed during reviews. There was no plan of action to check why this was the case and to ensure all people had the opportunity to feed back about their experience of the service.

The registered provider and the management team did not have a clear understanding of what was happening in the service. They were unaware of almost all of the issues we raised with them. The registered provider said that they did not think there were any concerns about the quality and safety of the service. The provider told us, "I definitely have enough staff. The problems we have are just at times of annual leave or sickness". The registered provider said at times of staff absence the staff would take on extra hours to make sure people got the support they required. They said that the office staff would also step in as they were trained to do so. However, we found that there were not enough staff to provide people with the care and support they had been assessed as needing.

Medicines administration audits had been carried out most months. However, the issues we identified when we checked people's records had not been noticed or checked. The audits that had been carried out were not robust enough to enable the registered provider to be sure about the quality and safety of the service provided. Issues that came to light during our inspection were not picked up by either of these two monitoring processes.

The registered provider had failed to maintain accurate, complete records. Time sheets were inaccurate, daily records did not reflect the support provided, complaints had not been recorded, accident and incident

reports were not always completed following incidents.

We asked the registered provider to provide us with people's daily records as we were told staff recorded the times they were present in each person's home in these. The registered provider also said staff would record the reasons why they had left early in the daily record. We found the times logged on staff timesheets were often very different from those hand recorded in the daily records. Records still showed that people had received less than their assessed and allocated time. Records evidenced that staff rarely gave a reason why they had not completed the full allocated care visit with people.

The provider had failed to establish and operate systems to effectively assess, monitor and improve the quality of the services provided. The provider had failed to maintain accurate and complete records. The provider had failed to seek and act on feedback from people and failed to improve their practice in relation to feedback received. This was a breach of Regulation 17 (1)(2)(a)(b)(c)(d)(e)(f) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

The ratings from the previous CQC inspection carried out on 15 January 2015 were clearly displayed within the reception area of the registered provider's office base.

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 9 HSCA RA Regulations 2014 Person-centred care Regulation 9(1)(a)(b)(c)(3)(b) The provider had failed to provide care and support which met people's needs and preferences.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1)(2)(a)(b) The registered provider did not adequately assess the individual risks to the health and safety of people. Regulation 12(g) The registered provider did not have measures in place to ensure the safe administration of medicines to people in their homes.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Regulation16 (1)(2) The registered provider did not have a consistent approach to respond to complaints or monitoring systems in place to learn lessons in order to improve the service provided.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1)(2)(a)(b)(c)(d)(e)(f) The registered provider did not have systems and processes in place to effectively monitor the quality and safety of the service provided.

The enforcement action we took:

A warning notice to ensure action is taken to become compliant with the Regulation

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18(1) Sufficient numbers of staff were not employed to be able to provide the assessed personal care needs of people using the service.

The enforcement action we took:

A warning notice to ensure action is taken to become compliant with the Regulation