Saffron Care Ltd

Saffron Care Agency

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection took place between 17 and 30 May 2018, the first day was unannounced. We last inspected this service in September 2017 where it was rated 'Inadequate' overall. At that inspection, we identified nine breaches of regulation. The Care Quality Commission (CQC) took enforcement action against Saffron Care Ltd and imposed a condition on the provider's registration. This required the provider to send us fortnightly and monthly reports on the areas of greatest concern and risk. This also included a requirement that the provider must give us information about the actions taken in response to any issues.

We met with the provider to confirm what they would do and by when to improve the service. The number of people who used the service had decreased from 260 to 156 people. The registered manager was receiving support from the organisation who sub-contract packages of care to them and the local authority quality assurance and improvement team (QAIT). Despite this support, this inspection has shown widespread and significant shortfalls, and some deterioration, in the service. The only improvement made, that has had a positive impact, was to staff recruitment.

Saffron Care Agency is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger adults. Not everyone using Saffron Care Agency receives a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the time of this inspection the service was providing care and support to 156 people.

The service had a registered manager who was also the 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.

We received concerns from people who used the service, staff and the local authority. In response to those concerns we brought forward this unannounced inspection. Prior to us starting this inspection the local authority placed the service back into a multi-agency safeguarding process due to the concerns they had received. We also shared our concerns with the local authority commissioners and safeguarding team. Concerns related to late visits and people being rushed during their visits, lack of staff training, medicines not being administered appropriately, poor communication and lack of response to complaints, and poor staff attitude.

People who used the service were still not safe. We looked at people's visit records and found staff were not always recording the time they arrived and left visits. This meant the registered manager could not assure us that visits were being carried out as agreed. We found examples of people being rushed, not getting their full visit time, and care being missed. Incidents that should have been reported as safeguarding alerts had not been sent to the local authority without delay. People did not always receive their medicines as prescribed.

When people's regular staff were not working, staff who carried out visits didn't always know people or how to meet their needs. We found examples of staff being expected to use equipment when they had not received appropriate training. This included training in how to put on support stockings, using a hoist, catheter care, and supporting people with their oxygen and nebulisers. Some people told us they felt unsafe. One person said "I have issues relating to my safety and the training or lack of training of carers on using my hoist".

People told us when their regular care staff were not working, they did not receive the same caring service. One person commented "Some of them are very aggressive, some patronising". People's preferences were not always listened to and respected. Where people had asked for certain staff not to support them, this was not always respected. Several people told us some staff who visited them didn't speak to them. One person told us this made them feel sad as they liked to have a chat.

People's complaints were still not taken seriously, explored thoroughly or responded to. We found complaints that hadn't been recorded correctly. Complaints records did not contain clear information relating to investigations, outcomes and action taken in response to the complaint. The compliance manager had delegated actions to team leaders and field trainers to resolve issues. We found these actions had not been taken.

Some people still didn't receive person-centred care because some staff were not aware of their needs before visiting them for the first time. The management had discussed ways of getting information out to staff in September 2017 but staff told us they still didn't receive information. People's care plans were still not always reviewed and updated to reflect their current needs. Staff told us there was not enough time for team leaders to update care plans due to them carrying out other duties.

People were still placed at risk because there continued to be a lack of leadership, governance and managerial oversight of the service. People and their relatives told us the service was not well managed. Comments included "This company is not well led. You can talk to (registered manager's name) and he promises things will be sorted out and they aren't" and "The service isn't learning. The company is poor and lets down some of the good carers they have". Other people told us they were happy with service they received and felt some improvements had been made.

People and staff told us there was still a lack of communication. Staff we spoke with were passionate about their work and knew changes needed to be made but were frustrated by the organisation. Staff commented "Things have got worse not better" and "it's so badly run". Staff gave us examples of being spoken down to and not treated equally. When staff had raised concerns these were not taken seriously and action was not taken. Staff told us this had impacted on their morale and staff had left the service as they were unhappy.

The registered manager said he would take actions following the previous inspection. They told us a number of actions had been completed but we found there were ongoing issues which are described throughout this report. Quality assurance systems did not ensure people's individual care needs were met, risks were minimised or care was delivered to keep people safe.

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 service is 'Inadequate' and the service continues to be 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 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.

People's care needs were not met because they did not receive their visits as agreed.

Where risks had been identified action had not been taken to ensure people were safe.

Systems and process in place to prevent abuse were not being operated effectively.

Medicines were not managed safely.

Staff recruitment processes were safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Some staff had not received specific training to ensure they were able to meet people's needs.

Staff did not always receive the support they needed to carry out their role effectively.

People benefited from staff who supported them to manage their healthcare needs by contacting healthcare professionals.

Is the service caring?

Inadequate

The service was not caring.

People could not be assured they would receive care that respected their preferences and what was important to them.

People were not always treated with dignity and respect.

Some staff were caring and people had built good relationships with them. Other staff were not caring towards the people they supported.

Is the service responsive?

Inadequate

The service was not responsive.

Complaints were not thoroughly investigated and practice was not changed as a result.

People did not always receive consistent, personalised care and support as staff did not receive enough information about them.

People were placed at risk of inappropriate care and support as care plans were not always updated when their needs changed.

Is the service well-led?

Inadequate

The service was not well-led.

People continued to receive a poor quality service because issues were not identified and resolved.

There continued to be a lack of leadership, governance and managerial oversight.

Systems for identifying and managing organisational risks were ineffective.

The provider had failed to send us information, required by law, so we knew what was happening in the service.

Saffron Care Agency

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.

We received concerns from people who use the service, staff, and the local authority. Concerns related to late visits and people being rushed during their visits, lack of staff training, medicines not being administered appropriately, poor communication and lack of response to complaints, and poor staff attitude. In response to those concerns we brought forward this unannounced inspection. Inspection site visit activity started on 17 May and ended on 30 May 2018. It included speaking with people and their relatives on the telephone, visiting people in their own homes with care staff, and speaking with staff. We visited the office location on 17 and 30 May 2018 to see the manager and office staff; and to review care records and policies and procedures.

Two inspectors carried out the first day of inspection at the office. One inspector carried out six visits to people in their own homes on 21 May 2018. Two experts by experience made telephone calls to people who used the service and their relatives on 22, 23 and 25 May 2018. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was care for older people. During this inspection, we spoke with 29 people and 7 relatives.

We reviewed the concerns we had received. We looked at the notifications we received. Notifications are sent to the Care Quality Commission by the provider to advise us of any significant events related to the service, which they are required to tell us about by law.

During the inspection, we spoke with 18 staff, the compliance manager, the office manager, and the registered manager (who was also a director of the provider organisation). We reviewed a compliment from one healthcare professional. We looked at 12 care plans including risk assessments, visit records, and records relating to medicines. We looked at 12 staff files. We checked how complaints were managed and quality was monitored.

Inadequate

Is the service safe?

Our findings

At the previous inspection in September 2017, we found people were not kept safe or protected from risks. We rated this key question 'Inadequate' and identified concerns relating to people's visits, medicines management, safeguarding, risk management, and staff recruitment. At this inspection, we found that most of the issues identified at the previous inspection continued to be a concern. We found improvements had been made to staff recruitment and the required checks were in place before staff started working with people.

The way staff were deployed and the way that rotas were written meant that staff could not always meet people's needs, particularly when regular care staff were not working. People told us they were happy when their regular care staff were working with them but they had experienced difficulties when they had days off or went on leave. One staff member told us they were constantly running behind and a team leader had come out to do some of their visits to help them catch up. One person commented "Sometimes I feel rushed, the one I complained about was awful, walking out of the door more or less as she came in". Another person's relative told us about a staff member who was rushing. They had to go out of the house and get the staff member back as they hadn't completed everything in the care plan.

People were at risk because staff did not attend to all their needs during visits, and some visits were cut short. A staff member didn't have time to prepare one person's meal, in accordance with their care plan. Daily records stated "Running late today, too many clients apologised couldn't help with tea preparation." The staff member's visit record showed they stayed for 12 minutes of the 30 minute visit. Following this visit, four 30 minute visits that followed were carried out in the less than the agreed time; these visits lasted 14 minutes, five minutes, 11 minutes, and one minute. We asked the registered manager whether this had been followed up. They told us they had not spoken with people to ensure their care had been carried out as per their care plan.

Another staff member carried out a 30 minute visit in 11 minutes and didn't give the person their medicines. We found this had not been followed up with the staff member although 12 days had passed since the incident.

Some people were at risk because of the scheduling of visits. Staff visit records showed some visits were being carried out over an hour earlier than their agreed time. Several visits were booked at the same time and some visits overlapped for the same staff member. Staff told us they did not always have enough travel time between visits. One staff member told us about a recent road closure which had impacted on travel times. They said although this had been raised with the registered manager, no changes were made to visit times. Another staff member told us about their experience of covering visits on a shift. They said the regular staff member moved visits around to meet people's preferences. When they arrived at one person's house at the agreed time, they were told they weren't needed as the regular staff member usually visited a lot earlier.

One person told us they had asked not to have male care staff due to their personal history. They said "At times when short of staff they have turned up to do my care.

This showed people did not always receive their visits as planned and staff did not always stay for the length of time they were supposed to.

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

People remained at risk of not receiving appropriate care and support. Following our previous inspection, the registered manager had introduced a new electronic system to monitor people's visits. We looked at people's visit records and found staff were not always logging in and out of the system. We looked at visit records in people's homes and found that staff did not always record the time they arrived and left. This meant the registered manager could not assure themselves that visits were being carried out as agreed.

People were at risk because they did not always receive their scheduled visits. We found evidence that one person had a missed visit on 12 April 2018. Records showed the person had not been visited. The staff member who carried out the lunch visit informed the registered manager of the missed visit.

Another person told us they rang the office when their evening visit was late. The visit record showed the visit was due at 6.50pm. The person told us staff arrived at about 8.20pm. The staff member didn't log in or out.

After the last inspection we required the registered manager to let us know about any missed visits or visits that were over an hour late. These visits were not recorded on the report we received. This showed visits had been late or missed and we had not been informed, as required.

At the last inspection people told us they did not receive a rota to tell them who would be providing their care and at what time. At this inspection, people told us they still didn't receive a rota. This meant people did not always know who would be visiting them or when they would receive a visit. The registered manager told us people could have a rota it they requested this. People said "I don't get a rota so I have to ring the office to find out who is coming to care for me at the weekend as this is when I might get carers who are not aware of my routine or how time critical my care is" and "I don't get a rota but would really like one. I get new carers and never know until they get here."

People were at risk because staff had not always been supported to gain the skills necessary to care for people safely. For example, one person experienced breathlessness and used oxygen in their home. Their relative raised concerns, with the service and CQC, as some staff who attended visits did not know how to support the person to use the oxygen. Following the concerns being raised, records showed the service continued to send staff who were not trained in how to safely support someone using oxygen. The service's medication policy states "Care staff may only support people to use their oxygen if they have been trained and assessed as competent to do so." On the first day of our visit, we asked to see the risk assessment relating to the oxygen. The registered manager told us these records were in the person's home. When we returned to the office, we saw a standard generic risk assessment had been put in place after we asked for it. No information relating to the person or the risks had been added.

One person had complex moving and handling needs. When their regular staff member was working, they showed other staff how to use the equipment. However, when the regular staff member was not available this person told us "I have issues relating to my safety and the training or lack of training of carers on using my hoist". Another person's relative said "If (registered manager) sends an experienced carer with an unexperienced carer on shower day it puts (person's name) at risk." During a spot check in May 2018, a staff member had to be reminded to hold onto a person when they were in the hoist. There was no evidence on

the staff file to show that a further spot check had been carried out to check their practice had been amended

Sufficient action was not always taken to manage risks to people. Staff had raised concerns about a staff member who had put a stocking on a person's leg and it had resulted in bruises. Two staff members were named and the service was not sure which one had caused the bruising. The compliance manager identified a need for training in putting the stocking on and spot checks at the person's home for both staff. Records showed the service had not completed these actions. The incident took place on 26 April 2018 and had not been addressed by 30 May 2018. This showed the service had not learnt from this incident and taken action to reduce the risk of a reoccurrence.

Staff did not always have the information they needed to meet people's needs. People told us staff who visited them when their regular staff were off did not always know how to meet their needs. One staff member told us, when they were new to the service, they had been sent out to people they had never met and knew nothing about. Staff told us they sometimes had difficulty getting hold of team leaders for advice, as they had been covering care visits.

People did not always receive their medicines as prescribed by their doctor. We found gaps in people's medicine administration record sheets (MAR). We found several occasions where one person did not have their prescribed nutritional supplements available to them as staff had not arranged the prescription before the supply ran out. Visits were still not being spaced correctly to ensure people could take their painkillers at the times they were needed. This meant the appropriate levels of medicine would not be maintained in the blood stream to ensure pain relief was managed.

People were not supported to take their medicines safely. We found staff were using a code 'made available' on the MAR sheet. Staff were leaving medicines out for people to take later. This had not been risk assessed or included in their care plans. One person's daily records showed staff had found a tablet in the bed. One person said "They don't check I have taken it and I have found tablets on the floor after they have left."

The policy we received did not reflect the National Institute for Health and Care Excellence (NICE) guidance 'Managing medicines for adults receiving social care in the community'. This guidance was published in March 2017. This meant the service was not following good practice guidelines. We were told by the manager that the policy was under review.

People were being placed at risk of cross infection. Although we observed staff washing their hands and wearing gloves appropriately, and most people told us staff did all they could to prevent and control infection, several people told us staff did not always wash their hands or wear gloves.

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

Safeguarding policies and procedures had not been followed to ensure people were protected from the risk of harm. Records showed one person had alleged a staff member had been verbally abusive towards them. The person had reported the incident on 12 April 2018. The registered manager confirmed the staff member admitted this had happened. The staff member asked for 'behaviour challenges' training. This had not been completed at the time of our inspection. The registered manager told us they had informed the local authority safeguarding team of the incident via a safeguarding alert. The local authority told us they had not received a safeguarding alert.

A staff member had raised concerns that another person may be subject to abuse with a manager on 20 April 2018. The concerns had been logged as a 'whistleblowing/safeguarding' issue. When these types of issues are raised, the form that is completed includes a section entitled 'is any action required?'. This was left blank. The registered manager had read and signed the form and not taken any action. It was not until a month later that these concerns were reported to the local authority safeguarding team on 21 May 2018.

This is a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection, we found recruitment practices were not safe. At this inspection, improvements had been made and the required checks had been carried out before staff started work. These checks included written references, satisfactory police checks (Disclosure and Barring Service or DBS), and confirmation of identity. This helped reduce the risk of the provider employing a person who may be unsuitable to work in care.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection in September 2017, we found people did not always receive support from staff who were competent and skilled to meet their needs. We rated this key question 'requires improvement'. At this inspection, we found this continued to be a concern.

We received concerns in November 2017 about the training being provided to staff. We shared these concerns with the registered manager, who is also the owner. He responded by saying the training had been reviewed and this had resulted in any shortfall in carer competency being quickly identified and addressed.

However, during this inspection we found some staff were not adequately trained to meet people's individual needs effectively. People told us about their experiences of being visited by staff who did not know how to meet their needs. Comments included "They are not trained. I have to repeat myself over and over" and "They're not trained properly." Several staff told us when they had time off work, they found things hadn't been done properly when they returned.

At the previous inspection, the registered manager told us they had further training planned to address issues with staff not knowing how to put on support stockings, use a hoist, or care for a catheter. At this inspection, one person said "I think they could do with professional training some of them, like the stocking thing". A staff member said "I had trouble putting a stocking on yesterday." They confirmed they had not completed any training in this area. Another person told us about their experience of care staff using their hoist, when their regular care staff member was off sick. They said "None of the carers were competent the sling being the biggest problem. I tried to help them but some couldn't take it in." A staff member told us they hadn't completed any training in catheter care with the service. They told us they relied on their previous training and experience. Another staff member said they had not completed training in catheter care or putting stockings on for people.

In addition, we found examples of staff visiting people before they had received specific training in how to use a nebuliser and support a person with oxygen. A relative told us they had shown some of the staff how to support a person with oxygen. The registered manager told us there was no specific training in administering oxygen and knowledge was passed from staff member to staff member. One person who used a nebuliser commented "One of the night girls who came said she didn't know how to use it. She said "will you show me". A staff member who visited a person who needed support with their nebuliser commented ""It was really frustrating, I was sent in and didn't know what I was doing".

The provider held four day induction training sessions where staff completed the core theory of the care certificate. This certificate is an identified set of standards that care workers use in their daily work to enable them to provide compassionate, safe and high quality care and support. The pilot of the Care Certificate showed that for full time staff who were new to care, the average length of time to demonstrate the expected competencies and knowledge was 12 weeks. Staff told us "The induction was really chaotic, jumping from subject to subject" and "A lot to take in, in one go." An experienced staff member said "New staff are very rushed, they're straight out there". This was confirmed by a new staff member who told us they

had been expected to go out on their own before they had completed appropriate training, shadowing an experienced staff member.

Some staff felt well supported but others felt support needed to be improved. One staff member said "There's a lack of support. Staff not being helpful". Two other staff members commented that they didn't always know which team leader was covering the on call duty. When they did get hold of a team leader who didn't cover their area, they said it could be difficult to get the advice they wanted as the team leader didn't know the people they visited. Other staff said "The support is fantastic. I can phone in" and "The personal support is amazing." Several staff told us their team leader was really good and would take calls at any time, to support them.

When staff competencies were identified as needed to be improved, sufficient action was not taken to address this. Observations of staff's work practices were carried out regularly. We saw that issues with staff competencies, such as using the hoist and medicines management, had been identified during these observations. For example, one staff member had not completed the medicine administration record sheet correctly. On 17 May 2018, It was identified the staff member should attend a medication workshop. The staff member had not attended a workshop by the end of the inspection on 30 May 2018. The registered manager told us they planned to start workshops.

Although records showed staff received regular supervision, these records also showed that insufficient action was taken to address issues raised during supervision to ensure staff were supported to carry out their duties.

This showed the registered manager did not have an appropriate training or support programmes in place to ensure all staff were able to meet people's needs and carry out their role effectively.

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

We received positive feedback about the regular care staff who supported people. Comments included "My current carers are well trained to meet my needs"; "I have learnt a lot from the carers as to ways I can help my husband"; and "I have two diamond carers come in, they know what to do."

Staff supported some people with their meals. People commented "They always leave me with snacks, drinks and fruit" and "They do my wife's lunch and ensure she has hot drinks. They do it well." One person said some staff didn't know how to boil an egg or make a sandwich which meant they had to teach them how to do their meals. Staff told us they always offered people a choice of their preferred foods and we observed staff offering a choice of dishes during our home visits. Staff knew to contact the office or health professionals if people did not eat enough or they had any other concerns in relation to eating.

Most people, or their relatives, who used the service were able to contact healthcare services independently. Staff told us if they had concerns about people's health they would ring the appropriate professional themselves or let a relative know. We saw evidence of occasions when people were not well and staff had supported them to seek advice. For example, staff identified a concern in relation to one person's skin. They advised the person to contact health professionals. We saw this person had contacted a health professional and they received appropriate treatment as a result.

Some people who used the service were living with dementia. We checked whether the service was working within the principles of 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 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. At the time of our inspection, each person had capacity to make decisions relating to their care.

Care plans were signed by each person and showed consent to care and treatment had been obtained. Staff told us they gained consent from people before carrying out personal care and respected people's choices. Most people confirmed staff checked they were happy for them to carry out personal care.

Inadequate

Is the service caring?

Our findings

At the previous inspection in September 2017, we found people did not always receive support from staff who were caring and treated them with dignity and respect. We rated this key question 'requires improvement'. At this inspection, insufficient action has been taken to address the concerns raised. Whilst some staff were caring, the service did not support a culture which fully promoting caring.

The registered manager told us they had increased spot checks. This meant staff's work practice was being observed more regularly. Despite this, people continued to receive support from staff who were not caring and did not treat them with dignity and respect.

People told us everything went well when their regular care staff visited them. When the regular care staff were not working, people told us they did not receive the same caring service. People commented "One of my carers can be a bit of a problem as they are a bit sharp and controlling" and "Some of them are very aggressive, some patronising". One staff member said "I wish (registered manager's name) would recruit staff who are dedicated to care."

People were not always treated with dignity and respect. Several people told us some staff who visited them didn't speak to them. One person told us this made them feel sad as they liked to have a chat. Another person said "I have a good rapport with most carers but I am not keen if I get a carer who is reluctant to speak. I treat them with respect and expect them to do the same". A staff member said "Lots of new carers don't talk with clients, they just do things quickly without thinking about clients."

This is a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's preferences were not always listened to and respected. The registered manager told us they had created a 'client preference' list. This list was to be reviewed against the rota to ensure people were supported by appropriate staff. We found where people had asked for certain staff not to support them, this was not always respected. For example, one person said "One carer was very rude to me on two occasions and asked they did not send her again but they ignored my wishes". This person was unhappy with the response from the service, and reported this to the local authority. Another person continued to raise concerns with the service over the gender of the care staff who visited them. This had not been actioned despite being raised formally in a review.
Other people were keen to tell us how caring their staff were. Comments included "we're good friends", "We have a laugh and a joke" and "They're lovely." Staff we spoke with were keen to provide compassionate care. Comments included "My clients are lovely" and "No matter how rushed I am, I always take time to talk with them, I might be the only person they see". In relation to one person's care, a healthcare professional said "The carers are always professional, polite and kind in their approach."

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

During home visits, we saw interactions between staff and people which were respectful and kind. The two staff we went out with knew people well and had a good understanding of each person's needs, preferences, interests, and personal history. Staff asked people what they would like to do, offered choices, encouraged independence and took their time to make the visits enjoyable for people. Staff were professional and respectful throughout the visits.

One person was not feeling well and the staff member was patient. They ensured the person only did what they felt able to do and wanted to do, at their own pace. The other staff member had taken their newspaper into a person so they could look at the photographs of the royal wedding. They knew the person was keen to follow the royal family and had taken them a framed photo of a previous royal wedding.

Inadequate

Is the service responsive?

Our findings

At the previous inspection in September 2017, we found people did not always receive consistent, personalised care and support and complaints were not well managed. We rated this key question 'Requires improvement'. At this inspection, we found this continued to be a concern.

Complaints were still not recorded, investigated, and acted upon. People told us "Nothing ever changes no matter how often you complain" and "(Registered Manager's name) takes far too long to react to complaints if he responds at all."

The registered manager stated on the monthly report they send to us "We continually review how we record and deal with concerns/complaints, to make sure we are taking appropriate action, where necessary."

Between 4 April 2018 and 17 May 2018, we saw the service had received 47 concerns and one complaint. The complaints procedure made a distinction between concerns and complaints. We found that some of the records logged as concerns should have been logged as complaints or safeguarding concerns. The procedure stated that concerns would not be formally acknowledged or responded to. We found concerns and complaints had been archived before they had been resolved. For example, the complaint in relation to one person's oxygen had not been resolved or responded to. Staff had not completed appropriate training in supporting this person with their oxygen and staff without this training continued to support this person.

One person told us about complaints they had made in April 2018. However, the registered manager told us they didn't have any recorded complaints for this person. Records did not contain clear information relating to complaints, investigations, outcomes and action taken in response to the complaint. The compliance manager had delegated actions to team leaders and field trainers to resolve issues. We found these actions had not been taken. For example, they had emailed the training manager and field trainers on 26 April 2018 asking for training and observations of staff's work practice. This had not been followed up to check the actions had been taken. The registered manager did not monitor complaints or look for trends and areas of risk that may be addressed.

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

People still didn't receive person-centred care because staff were not aware of their needs before visiting them for the first time. The management had discussed ways of getting information out to staff in September 2017. At this inspection, staff told us they still didn't receive information about people's needs before their first visit to them. One staff member told us they rang the office as they wanted to know more about the person before they went in. People told us about their experiences of staff who hadn't been to them before. Comments included "new carers didn't read my care plan beforehand I had to insist they did" and "I find it frustrating that carers don't read my care plan when they first come."

People's care plans were still not always reviewed and updated to reflect their current needs. Staff told us

there was not enough time for team leaders to update care plans due to them carrying out other duties. People commented "We have a care plan, initially it was very good and we had a team leader then it went haywire" and "Can't remember the last time this was done." A staff member said "Care plans are not always up-to-date and risks are out of date."

We looked at the care plan for a person who had been discharged from hospital. Their care package had increased from one visit to three visits a day for a one week period. There was no care plan relating to the additional two visits. The registered manager told us there may have been a prompt sheet for staff but there was no evidence of this.

Another person had a change to their skin care needs after a visit from the district nurse. Instructions were contained within the daily records but had not been added to the care plan.

This meant staff did not have clear information to follow and people may have been placed at risk of inconsistent care.

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

We saw care plans contained standardised statements that may not be appropriate for each person. For example, the section on skin integrity stated "Carer on each visit check pressure areas, bottom, sacrum, shoulders, heels, ears, elbows and ankles." This statement was included in people's care plans if there were no concerns.

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

Staff supported people to receive care at the end of their life. The registered manager told us they were not supporting anyone at the time of our inspection. One person's relative had written "The care team have shown themselves to be flexible and adaptable to her ever-changing needs, and have worked with us as a family to ensure a consistent, holistic and very caring approach."

Inadequate

Is the service well-led?

Our findings

Saffron Care Agency was managed by a person who was registered with CQC as the provider and registered manager for the service. At the previous inspection in September 2017, we found people were placed at risk because there was a lack of leadership, governance and managerial oversight of the service. We rated this key question 'Inadequate'. At this inspection, we found that issues identified at the previous inspection continued to be a concern and the service being delivered had in some areas deteriorated due to the lack of sufficient action by the registered manager/provider.

Since the previous inspection, the number of people who used the service had decreased from 260 to 156 people. The registered manager had received support from the organisation who sub-contract packages of care to them and the local authority quality assurance and improvement team (QAIT). The purpose of this was to bring about improvements.

Despite this support being provided, at this inspection, we found widespread and significant shortfalls in the way the service was led. The registered manager had failed to make robust or timely improvements. There were eight continuing breaches of regulations. This meant people received poor quality care and were placed at risk.

Prior to us starting this inspection, the local authority placed the service back into a multi-agency safeguarding process due to the concerns they had received. We also shared our concerns with the local authority commissioners and safeguarding team. Concerns related to late visits and people being rushed during their visits, lack of staff training, medicines not being administered appropriately, poor communication and lack of response to complaints, and poor staff attitude. We fed back our continuing concerns at the end of the inspection. The registered manager shared with us that they do not plan to take any new packages of care at this time.

Some people and their relatives told us the service was not well managed. Comments included "This company is not well led. You can talk to (registered manager's name) and he promises things will be sorted out and they aren't" and "The service isn't learning. The company is poor and lets down some of the good carers they have" and "I would recommend my principle carer but not the agency. If she leaves I would have to carefully consider my situation with Saffron." Other people were happy with the service they received and felt some improvements had been made.

People and staff told us there was still a lack of communication. People told us they were not kept informed about any changes to their care. We heard of many examples of people phoning the office and not receiving a response.

Staff we spoke with were passionate about their work and knew changes needed to be made but were frustrated by the organisation. Staff commented "Things have got worse not better", "it's so badly run" and "lots of changes in office staff, difficult to know who's who." Several staff told us they had been ignored when they went into the office and didn't feel listened to. Staff gave us examples of being spoken down to

and not treated equally. When staff had raised concerns these were not taken seriously and action was not taken. Staff told us this had impacted on their morale and staff had left the service as they were unhappy.

Three days after our inspection started, the registered manager sent staff an update by email. It stated "I have few ideas of the sort of things that you need to be thinking of when speaking to CQC; these are an example of positive outcomes that we do that would reflect really well." This suggested pre-prepared statements for staff to say to us. Some staff said this made them feel pressured. We asked the registered manager why they had done this. They said "To mentor staff about what things to be saying." They told us they had taken these sentences from the Skills for Care 'Outstanding' rating resources.

Quality assurance systems were not operated effectively to monitor quality or minimise risks to people. The registered manager said he would take actions following the previous inspection. We asked for an updated action plan in April 2018. This was to include how they had met each of the regulations that were in breach at the previous inspection. The action plan contained limited information. The registered manager told us a number of actions had been completed but we found there were ongoing issues which are described throughout this report.

Following the last inspection CQC imposed a condition on the registration of this service, requiring the registered manager to send us reports on a regular basis relating to any missed and late visits, medicines management, and complaints. If any issues were identified the registered manager was to report what actions had been taken to address those issues. Where the manager reported to us that audits had identified issues they told us they had investigated and resolved these. We found issues had not been investigated and resolved. These related to each of these areas. For example, where complaints had been received, the registered manager told us they had been dealt with promptly and appropriate action had been taken. We found complaints had been archived before they were resolved.

Records were not always accurate or up-to-date. We had been informed of two safeguarding outcomes for people. In January 2018 a staff member did not report an incident to the office. The registered manager told us the staff member was on an action plan and was receiving mentoring. There was no mention of the incident in the staff's file. We asked the registered manager about this. They told us the compliance manager who had left their employment had dealt with this. The other incident took place in March 2018. The registered manager said they would carry out supervision with the staff member the following week and action would be discussed. The staff member's file had no evidence of the discussion. The registered manager told us it should be in the file and that they didn't do the filing. Daily records were not always written clearly so other people could read them.

Surveys were sent to people in December 2017. The results were collated into percentages and the registered manager told us 113 people had completed the survey. The people who responded were mostly positive. One person said "I didn't fill in the last one as none of the questions tie in with my care". One of the improvements made as a result of the survey included updating all rota times to ensure sufficient travel time was allocated between visits. We found evidence during this inspection that this improvement had not been sustained.

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

We found that the registered manager had failed to report safeguarding concerns appropriately. They confirmed they had not notified us, as legally required. One of the required notifications was sent to us retrospectively during the inspection. The other required notification was received after we asked for it and

gave the registered manager a further reminder. This showed the registered manager still did not have systems in place to ensure important information was communicated.

This is a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the Care Quality Commission of significant events and incidents affecting people's safety and well-being.

The enforcement action we took:

We issued a notice of proposal to cancel the regulated activity of personal care.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people received person-centred care. People's preferences were not respected.

The enforcement action we took:

We issued a notice of proposal to cancel the regulated activity of personal care.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were treated with dignity and respect. Staff not always kind. Some staff did not speak to people in their own homes.

The enforcement action we took:

We issued a notice of proposal to cancel the regulated activity of personal care.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure people received care and treatment in a safe way.

Medicines were not managed safely.

People were placed at risk of cross infection.

The enforcement action we took:

We issued a notice of proposal to cancel the regulated activity of personal care.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure people were protected from abuse and improper treatment.

The enforcement action we took:

We issued a notice of proposal to cancel the regulated activity of personal care.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to establish an effective system to manage complaints.

The enforcement action we took:

We issued a notice of proposal to cancel the regulated activity of personal care.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems to assess, monitor and improve the quality and safety of the service. The provider failed to assess, monitor and mitigate risks to people's health and safety. The provider failed to maintain accurate, complete and contemporaneous care records.

The enforcement action we took:

We issued a notice of proposal to cancel the regulated activity of personal care.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were sufficient staff available to meet people's care needs and carry out visits as planned.

The provider failed to ensure staff received the training and support they required for their role.

The enforcement action we took:

We issued a notice of proposal to cancel the regulated activity of personal care.