PAJ Premier Care Limited

Caremark (Calderdale)

Inspection Report

Elsie Whiteley Innovation Centre,
Hopwood Lane,
Halifax,
West Yorkshire,
HX1 5ER
Tel: 01422 399414
Website: www.caremarkcalderdale.co.uk

Date of inspection visit: 15, 29-30 April 2014
Date of publication: 23/07/2014

Contents

Summary of findings

Overall summary

Caremark (Calderdale) is based in Halifax and provides personal care and support to people living in their own homes in Calderdale, Huddersfield, Brighouse and surrounding areas. At the time of our inspection the agency was providing a service to 107 people.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission.

The service has undergone a number of changes since November 2013 when enforcement action was taken due to breaches in regulations which related to the care and welfare of people, safeguarding and the management of complaints. As a result of the enforcement action the local authority suspended placements with this agency and the suspension was in place when we visited. We spoke with the local authority before the inspection and they confirmed the agency was working with them to make improvements to the service.

People told us they experienced late and missed calls which meant they did not receive the care and support they needed at the time agreed. The registered manager and senior staff did not always recognise when abuse had occurred and had not made appropriate referrals to the safeguarding authority. Communication between staff was poor which resulted in incidents not being reported and acted upon.

We saw disciplinary procedures had been followed for two staff, but the issues had not been referred to safeguarding. Both staff no longer worked at the service but had not been referred to the Disclosure and Barring Service by the provider. The Disclosure and Barring Service decides whether a person should be placed on a barred list which means the person would be prevented from working with vulnerable groups of people.

The registered manager told us all staff had received safeguarding refresher training since the last inspection, however they were not able to provide evidence to confirm this.

There was no evidence to show staff had received training in the Mental Capacity Act (MCA) 2005. MCA is law protecting people who are unable to make decisions for themselves.

Consent and capacity forms had not been completed for people with dementia, although their care records had been signed by relatives on their behalf. This meant it was not clear if the person had the mental capacity to consent to these decisions for themselves or if they had agreed their relative could be consulted.

We found risks to people were not always managed appropriately and risk assessments were not always in place to inform staff how risks should be managed safely.

Staffing arrangements were inconsistent. Some people told us their staff arrived on time and they had seen improvements in the service, however others said they experienced late and missed calls. People told us there were problems with staff at the weekends and new staff often did not know their needs which meant they had to tell them what to do.

Staff recruitment processes were thorough and this ensured appropriate checks were carried out before people started working at the service.

People told us they had been involved in decisions about their care, however we found care records were not up to date and did not reflect people's care and support needs.

People's health care needs were recorded and there were systems in place for people to access health care services when needed. Information about medicines was sometimes contradictory and not recorded well which may lead to people not receiving their medicines safely.

We saw evidence which showed some staff had received induction and ongoing training, although records could not be provided to confirm this training had been received by all staff. Some people told us new staff were accompanied by more experienced staff before working alone, others said they were not.

Staff received supervision and arrangements were in place to develop a training development plan for staff.

People and their relatives gave mixed feedback about the staff. Those who had regular care staff spoke positively about the care that was provided and said staff were kind, caring and helpful. Others who did not have regular care staff were less positive.

Summary of findings

People were involved in reviews of their care and staff showed a good understanding of people's needs and the support they required.

Complaints were not dealt with consistently. Some people were satisfied their concerns had been addressed, others felt their concerns had not been listened to.

The service was not well led and leadership of the service required improvement. We found systems in place to monitor the quality of the service were ineffective.

Satisfaction surveys received back from people who use the service and their relatives had not been reviewed.

Many of the surveys raised issues about how the service was run which the manager was not aware of until we brought this to their attention. This placed people at risk as issues raised had not been acted upon.

Quality monitoring systems were not effective or reliable. There was no evidence to show that complaints, safeguarding and incidents were analysed or that the learning from them was shared with staff and used to improve the service for people.

We are taking further action and will report on this when completed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found the service was not safe. There were no effective systems in place to monitor if calls had been completed by staff. People told us calls were often late or missed, which meant people did not receive they care and support they required.

We found incidents had occurred which the manager had not referred to safeguarding. This resulted in us making a safeguarding referral to make sure people were safe.

The manager told us all staff had received safeguarding refresher training since the last inspection, however they were not able to provide us with evidence to confirm this. There was no evidence to show staff had received training in the Mental Capacity Act 2005.

We found risks to people were not always managed appropriately and risk assessments were not in place to inform staff how risks should be managed safely.

Staffing arrangements did not always ensure safe practice. Some people told us their staff arrived on time and they had seen improvements in the service, however many people said they continued to experience late and missed calls.

Staff recruitment processes protected people by ensuring appropriate checks were carried out before people started working at the service.

Are services effective?

We found the service was not effective. People told us they had been involved in decisions about their care, however we found care records were not up to date and did not reflect people's care and support needs.

People's health care needs were recorded and there were systems in place for people to access health care services when needed. Information about medicines was sometimes contradictory and not recorded well which may lead to people not receiving their medicines safely.

We saw some evidence which showed staff had received induction and ongoing training, although records could not be provided to confirm this training had been received by all staff. Some people told us new staff were accompanied by more experienced staff before working alone, others said they were not.

Summary of findings

We saw some staff had received supervision and arrangements were in place to develop a training development plan for staff.

Are services caring?

We found aspects of the service were caring. People and their relatives gave mixed feedback about the staff. Those who had regular care staff spoke positively about the care that was provided and said staff were kind, caring and helpful. Others who did not have regular care staff were less positive.

We saw people had been involved in reviews of their care and staff showed a good understanding of people's needs and the support they required.

Are services responsive to people's needs?

We found the service was not responsive to people's needs. People's preferences and needs were discussed and agreed through the assessment process. People told us staff respected their choices and decisions.

Mental capacity assessments had not been completed in line with the service's capacity and consent policy. This meant people's mental capacity had not been considered in the decision making process.

The service was not responsive to people's needs in the way it was managed and delivered. People told us their calls were often missed or late and arrangements for supporting and introducing new staff were inconsistent. This meant people had to tell staff what to do to meet their needs.

People's complaints were not responded to consistently. Some people were satisfied the concerns they raised had been dealt with, others felt their concerns had not been listened to or addressed.

Are services well-led?

We found the service was not well led. The service has a registered manager who is also a director of the Company which owns the service.

Leadership of the service was poor. We found systems in place to monitor the quality of the service were ineffective.

Satisfaction surveys received back from people who use the service and their relatives had not been reviewed. Many of the surveys raised issues about how the service was run which the manager was not aware of until we brought this to their attention. This placed people at risk as issues raised had not been acted upon.

Summary of findings

Procedures for dealing with complaints were not implemented consistently. Although some complaints had been investigated and responded to appropriately, we found others had not. This meant people could not be assured that their concerns were being listened to and addressed.

Quality monitoring reports were not reliable and did not accurately reflect what was happening in the service. We saw the number of missed calls recorded on some weeks was incorrect.

Summary of findings

What people who use the service and those that matter to them say

Over the course of the inspection we visited seven people in their own homes and spoke to three people on the telephone.

One person said about the care staff who visited them, "They are always here and stay long enough. They do what I ask. I feel safe and they respect my decisions. I am happy with the staff."

Another person said, "I'm happy with Caremark, staff are alright. They ring up if they're going to be late."

One person said, "I am very well satisfied. I couldn't wish for better. They never miss but they do run late sometimes but that can't be helped. They look after me and do this well."

One person said, "I am happy with the service. It's always the same care worker that comes."

One person said about the staff, "They are really friendly and not bossy. I look forward to them coming. They try and tell me if they're running late"

One person said, " Carers are kind. I have to tell the new ones what to do. If new staff come they don't come with an experienced member of staff."

One person said, " Care is alright, it's okay. I ask them to do things and sometimes they do it and sometimes they don't, they are very short staffed. I'm treated not too bad by staff, but you can't rely on them coming at all the times."

One person said, " I'm in the process of moving services. I'm not happy at all but it isn't the carers, most are absolutely fine. The problem is communication and lack of it." This person told us they had had 20 different carers since the service started six months ago.

One person said, "Only a few carers have transport, so we get mainly walkers which is a problem. Quite happy with the carers, they're very pleasant and hardworking. Bit of a problem with them arriving on time."

One person said, "Carers are alright. Some turn up all the time but not bang on time."

We spoke with 15 relatives of people who used the service.

One relative said, "They come most of the time at the right time and stay for the right length of time. Staff are pretty good and kind, he is looked after well."

One relative said, "I'm happy now because regular people come. The staff understand my (relative) and they definitely have the right skills to look after her."

One relative said, "The service in the beginning was abysmal. It's better than it was and we're now getting regular staff six days out of seven. I don't know (registered manager). I've never had contact from them." This relative told us no one had discussed the support plan with them and said the care staff did not look at it when they visited. They told us on a recent visit one of the care staff had just signed the book and left, leaving the other care worker to manage alone.

One relative said, "The service is rubbish. We've had missed calls over Easter. No one lets you know if they're not coming. When you ring the office they do not know no one has turned up. I have complained so many times but nothing has happened. You get the same people for a few days until they have days off then they don't arrange for other staff to come. Weekends are the worst. It's the organisation of the company that's at fault."

One relative said, "We've had our ups and downs, it seems to have settled over the last 3-4 months. It's very hard to get hold of staff on a weekend if staff don't turn up. Staff do not read the care plans and sometimes rely on (my relative) to tell them what to do."

One relative said, "The service by and large is not too bad. Staff turn up, they never miss but might be a bit late sometimes. I speak my mind and they usually listen and respond satisfactorily. Staff are kind, very friendly. I don't know who (registered manager) is."

One relative said, "Difficult to measure service as nothing to benchmark against but no major issues and think they do a good job"

One relative said, "Massively unhappy and looking to move the service. Have had four incidents where medicines have been missed. I have spoken to (registered manager) numerous time but they're not

Summary of findings

aware of issues. Can't trust them to do what they should be doing. Couple of carers are very good but they're the exception. Turn up late at times. No communication, can't remember the last time they called."

One relative said, "On the whole quite good. Only three care staff cover this area so I sometimes have to help out the carers. Have had times when only one carer has turned up but only occasionally."

One relative said, " Gone through some ups and downs. Been short of staff and a few have come and gone. Not many staff covering this area. Not perfect, don't always let me know if they're going to be late. Two weeks ago (my relative) rang me as it was after 9am and call is supposed to be 8am. The agency had told (my relative) that I had agreed to a later time which wasn't true."

One relative said, "Generally very good, get the same carers Monday to Friday. Weekend cover can be a problem."

One relative named three carers who they said were very good and always stayed the right length of time. They said, " There are some others who don't come on time and don't know (my relative) well. Weekends are sometimes late and they don't ring to let me know."

One relative said, "We're okay at the moment as we have regular carers. Saturdays can be a problem and they rarely ring if they're going to be late. The field care supervisor came out to see us today to check if everything was okay, before that we hadn't seen anybody since the service started in November."

One relative said, "Regular carers are very good, quite happy with them. Sometimes tea visit is too early. It's supposed to be at 4.30pm but sometimes they come at 3.45pm and mum's out and then they've just left a note."

One relative said, "Compared to the other agency we had they do a good job. Generally have regular carers but any new ones that are sent I have to let them know (my relative's) needs which I feel is the sort of information that should be passed on."

Caremark (Calderdale)

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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

At the last inspection in November 2013 the service was not meeting the regulations we looked at. We took enforcement action by issuing warning notices for breaches against regulations which related to care and welfare, safeguarding and complaints. We also issued a fixed penalty notice (FPN) as the service was not notifying us of events as the law requires. The service have paid the FPN. At this inspection we checked to ensure the regulations had been met.

We inspected the agency over three days on 15, 29 & 30 April 2014. This was an announced inspection, which meant the provider was informed two days beforehand to ensure management and staff would be available in the office.

The inspection team consisted of a lead inspector and two other inspectors. Before the inspection we reviewed all the information we held about the agency and contacted the commissioning services in the local authority.

We used a number of different methods to help us understand the experiences of people who used the service. This included visiting people in their own homes and talking with people and their relatives on the telephone. We spent time looking at records, which included people's care records, and records relating to the management of the service.

At the time of our inspection there were 107 people who were receiving care and support from this agency. We visited seven people in their own homes and spoke with three people on the telephone. We spoke on the telephone with fifteen relatives of people who used the service and a social worker. We spoke with six care staff, the office manager, the care co-ordinator, the training co-ordinator and the registered manager.

Are services safe?

Our findings

People were not safe as the agency did not have systems in place to monitor if calls had been completed. This was confirmed in our discussions with the care co-ordinator, office manager and registered manager and the records we saw. There was a reliance on the person who used the service or their relative to report if a call had been missed or was late. We spoke with one person who required two care staff at their visit. They told us on a recent occasion two care staff arrived but one just signed the record to say they had been there and left straightaway as they had another call to attend. This left one care worker who provided the care with the support of the relative. In another example a relative told us no staff turned up for two calls and when they contacted the senior staff member on call they were not aware no one had been. The relative said, "No one lets you know if they're not coming. When you ring the office they don't know no one has turned up." This meant people were not safe as they could not rely on their care and support being provided when required which placed them at risk of harm.

One person told us their morning call had been missed recently and this meant they had been left in bed from 4.30pm the previous day until 12.30pm when their relative came round to visit. The records showed this person was a diabetic and needed help with washing and dressing, preparing their breakfast and prompting medication. The registered manager told us this had been investigated as a complaint but had not been referred to safeguarding.

We found the service did not respond appropriately to safeguarding concerns that were raised. We found communication between staff was poor which meant the registered manager and senior staff were not always aware of incidents that had occurred. For example, one relative told us of an incident where two care workers had visited and roughly handled their relative. The relative said the staff were rushing to get to another call and following their visit the relative contacted the senior staff member on call and said that they did not want the staff members visiting again. The registered manager was unaware of this incident until we brought it to their attention. There was no record of the incident, it had not been investigated and there had been no safeguarding referral.

We found the registered manager and senior staff showed a lack of understanding of safeguarding and the agency's safeguarding policy and procedures were not followed. The service's policy stated that if care workers failed to turn up to a scheduled visit then the service would treat this as a neglectful action, which the policy defined as abuse. We found the policy had not been followed and saw complaints had been raised about missed calls which had not been referred to safeguarding.

In one person's care record we saw safeguarding concerns had been raised about one of the care staff at a review in October 2013. When we spoke with the registered manager they were unaware of the concerns and confirmed these had not been investigated or referred to safeguarding.

We saw a satisfaction survey completed by a person who used the service in March 2014. In response to a question asking if care workers were professional and helpful, the person had stated 'all except one whose actions could be classed as abuse'. We discussed this with the registered manager who was unaware of the comment. The registered manager told us they would look into this matter. On the second day of the inspection we asked the registered manager what action had been taken. They said they thought the comment related to an incident which occurred in January 2014 and the care worker concerned had left. However, the registered manager had not confirmed this with the person who had completed the survey and only did so when we asked them to. There were no records to show how the incident in January 2014 had been dealt with other than removing the care worker from the person's call.

We saw allegations of verbal abuse and neglect had been made against two care staff. These were investigated by the service and resulted in one staff member being dismissed for gross misconduct and the other was subject to disciplinary action and left the agency. The registered manager told us these allegations had not been referred to safeguarding and the staff members had not been referred to the Disclosure and Barring Service. This contradicted the actions to be taken as stated in the safeguarding policy. Following our inspection we contacted the local safeguarding team and made a safeguarding referral. The safeguarding concerns we identified meant there had been a breach of the relevant legal regulation (Regulation 11) and the action we have asked the provider to take can be found at the back of this report.

The registered manager told us all staff had received safeguarding refresher training since the last inspection,

Are services safe?

which they said included testing staff knowledge on safeguarding procedures and abuse. The training co-ordinator told us new staff were given a safeguarding workbook to complete as part of their induction and this was marked by the training co-ordinator. We spoke with one new staff member who confirmed they had been given the workbook. We saw a completed workbook for another staff member which had been marked and confirmed the staff member understood safeguarding. However, we found some of the answers the staff member had given showed a lack of knowledge and should have been explored further. For example, in answer to what happens if you miss a call, the staff member had answered, "The field care supervisor finds out". There was no record to confirm all staff had received safeguarding training. The training co-ordinator confirmed the training matrix was not up-to-date and said they were in the process of going through staff training records to update the system.

We asked the training co-ordinator if staff had received training in MCA and they said they did not know.

We found risks to people were not always managed appropriately. For example, we saw information from the local authority which showed one person sometimes left their back door open which was a security risk. This was not reflected in the environmental risk assessment drawn up by the agency. The office manager said this had been overlooked. For another person the daily records showed a number of risks relating to medication and the safe use of the oven. This person had dementia and lived alone and there were no risk assessments to advise staff how to manage these risks safely. The daily records showed another person had been found outside by a neighbour and was very confused. An ambulance had been called and they had been admitted to hospital. The office manager was unaware the person had been found outside even though they had signed to say they had read and checked through the daily records. There was no evidence to show the care plan or risks assessment had been reviewed following this incident. No consideration had been given to further investigation as to why the person was outside or if the incident warranted a safeguarding referral. The registered manager told us the incident had not been referred to safeguarding as the person was just outside.

We found the staffing arrangements in place did not ensure safe practice. The registered manager told us they had addressed issues relating to missed and late calls by adjusting travelling times. They said staff were now phoning the office to advise if they were going to be late and office staff were contacting people to let them know. This was not confirmed in our discussions with people or the records we saw. Several people told us they weren't notified if staff were going to be late. One person said, "I have an 8am call, sometimes they come at 8.45am or sometimes after 9am. They do not often let me know they are going to be late." Another person, when we asked what could be improved in the service, they said give the staff more travelling time. One staff member told us they could not always get hold of a manager or supervisor in an emergency and that they did not have enough time to get to calls.

We looked at the recruitment records for three new staff. These showed all the relevant checks had been completed before the staff member commenced work.

Are services effective?

(for example, treatment is effective)

Our findings

We found people's care and support needs had not always updated following reviews. The registered manager told us people's care was reviewed every three months and after each review care records were updated. They advised one of the office staff was going through all the records to make sure the care records were all up to date.

We reviewed twelve people's care records and found a wide variation in the information recorded. For example, in one person's care records we found clear information about how the person preferred their care to be provided on each call. There were detailed moving and handling assessments which showed the equipment to be used and how to position the slings to ensure the person was moved safely. The call times were recorded including how many staff were required and the duration of the call.

The other eleven records showed people's care had been reviewed, but their care plans had not been updated even though the reviews indicated changes were required. For example, one person's care review in October 2013 stated they did not want male care workers attending. A further review in March 2014 showed on occasions male care workers were still being sent. There was no reference to the gender of care workers in the care plan which had not been updated since February 2013. The care records showed this person sometimes had behaviour that challenged staff and therefore ensuring the person received care from their preferred gender of staff was important. In another person's care records there were two documented incidents where the person had been aggressive towards staff. There was no information in this person's care plan to show how staff should manage this behaviour. A further person's records showed medicines supplies had run out and risks relating to the person's safety had increased. Neither the care plan or the risk assessments for this person had been reviewed or updated. This meant there had been a breach of the relevant legal regulation (Regulation 9) and the action we have asked the provider to take can be found at the back of this report.

We found one person's care plan showed they required support with personal care and keeping the home tidy. We visited this person at home and they told us they were happy with the support they received. We spoke with the care staff who were providing the support. We found staff were not following the care plan as they told us they were not offering the person support with personal care or recording when it was refused. We also found the staff were not wearing aprons and had not washed up the cups the person was using which were dirty. Staff told us they had nothing to clean the cups, yet we saw cleaning products were available but had not been used. This person did not have a care plan available in their home for staff reference.

We found some specific information about how people communicated had not been transferred to their care plans. For example, information from the local authority showed one person could not verbalise their needs and explained the non-verbal signs used by this person. There was no reference to this in the person's care plan. This meant that staff were not provided with accurate information about how people communicated, which meant they may not understand what people were saying about their care and support.

We found people's health care needs were recorded and there were contact details for healthcare services recorded in their care records. We saw referrals had been made quickly to health care services when people's needs changed. For example, records showed staff had called an ambulance when they had found one person had collapsed and stayed with the person until they left for the hospital.

There was contradictory information about people's health care needs in the records we saw. For example, one person's care plan stated the person self-medicated and the needs assessment stated family supported the person with their medicines. The daily records and care summary on the staff rotas showed staff were prompting medication and applying cream to different areas of the person's body. When we asked the office manager about this, they could not explain. They said staff should not be prompting medicines or applying creams to this person and they would look into why this was happening. We saw records which showed creams were being applied to two other people although this was not recorded as part of the care plan or recorded on a medicines plan. This meant information about the medicines people were taking was not clear and the support required from staff to ensure people received their medicines as prescribed was not clarified. The office manager told us a new medication sheet had been introduced in April 2014 for staff to record when medicines had been prompted as this had not been recorded previously.

Are services effective?

(for example, treatment is effective)

The training co-ordinator told us they were updating the staff training matrix. They said there was no record which showed the training all staff had received and they were working through the individual staff files to put this information on the system. The training co-ordinator told us they were starting to identify people's specific training needs through supervisions and appraisals. They said this was at an early stage and there was no training plan currently but this was something they were hoping to develop. This was confirmed by the registered manager.

The training co-ordinator told us new staff completed eight workbooks as part of the induction process which covered all aspects of care provision including safeguarding. Mandatory training such as moving and handling was provided to new staff before they started work. The training co-ordinator told us all staff had a shadowing period where they worked alongside more experienced staff before they worked alone. We spoke with one new member of staff who confirmed the induction process and told us they had worked alongside a more experienced staff member for a week before working alone. However, our discussions with people and their relatives suggested this was not always the case. Although some people said new staff were accompanied by experienced staff, others said this did not happen.

We reviewed three staff records and found evidence of induction and training certificates for all three staff. We saw spot checks of staff practice had been carried out which assessed the delivery of service. We saw two of the staff had received supervision.

Are services caring?

Our findings

Feedback we received about staff from people and their relatives we spoke with was mixed. Generally those who had regular care workers spoke positively about them and described them as kind, helpful and friendly. They said they maintained their privacy and dignity and treated them with respect. They said the regular care workers knew their needs, stayed the right length of time and did a good job. These people told us they had noticed improvements in the service over the last few months and said things had settled down.

One person said "I'm happy with Caremark, staff are alright." Another person said, "They look after me and they do this well." A relative said, "Staff are pretty good and kind, he is looked after well." Another relative said "I'm happy now because regular people come."

In contrast other people told us they were not happy with the service and gave negative feedback about the care workers. These were usually people who had not received regular carers. One relative said they felt the care workers who visited their relative 'weren't bothered'. They said there were a couple of care workers who were very good but they were the exception. Another relative said, "The carers are kind but I have to tell the new ones what to do". Another person told us about a staff member who knocked and walked straight in without waiting for them to answer the door. This person had not made an appointment to visit and the person said the staff member was rude to their friend who was visiting. They said, "I'm not happy at all but it's not the carers, most are absolutely fine." We saw in a satisfaction survey one person had completed they had commented that the regular carers were fantastic but the staff who covered varied as some were good and others were poor.

Most of the people and relatives we spoke with confirmed they had been involved in care reviews. One relative told us they had a care review with the social worker, their family member and agency staff which they felt had gone well. We spoke with the social worker who was involved with this person's care and they praised the service provided. They said in their experience the care staff who visited the person were very good and some went above and beyond what was expected.

Some people told us they received copies of the reviews, others said they were not given copies and felt they should have been provided with them. We saw the agency used other methods to gain people's views such as telephone review calls, spot checks and the use of satisfaction surveys.

Staff we spoke with understood people's needs well. We saw people's support plans were available when we visited people in their own homes and copies were kept in the agency's offices. Staff were unable to locate one person's care plan when we visited the person in their home, however they told us they knew how to support the person from the information provided on their rotas. We saw staff rotas provided a synopsis of care for each person they were visiting, which staff told us they found useful.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We saw people's needs were assessed before the service commenced. The assessments showed that people care needs were discussed with them and included any preferences about how they wanted their support to be provided. We saw in some of the records there was information about people's living arrangements and their family relationships.

People we spoke with said staff respected their choices and decisions. One person said, "They do what I ask and respect my decisions." Another person said, " I am very well satisfied. I couldn't wish for better." Another person said, " Care is alright. I ask them to do things and sometimes they do and sometimes they don't." Another person said, "I speak my mind and they usually listen and respond satisfactorily." A relative said, " Compared to the other agency we had they do a good job."

We saw the agency had a policy for capacity and consent which referred to the Mental Capacity Act (MCA) 2005. There were no mental capacity assessments in the care records we saw for people who had dementia. For example, in one person's records, the section which asked if a capacity and consent form had been completed, stated 'not applicable'. We saw some people's care plans had been signed by their relatives on their behalf, but it was not clear if the person's mental capacity had been considered. The capacity and consent policy stated information should be recorded to show who may be consulted about the person's choices, who the decision makers were and what decisions they were responsible for.

Several people told us the service was not always reliable as calls were often missed or late, which meant that they did not receive the care and support they needed at the agreed time. Some people told us there had been improvements in recent months, however others said there continued to be problems. They said they were not notified if staff were going to be late and on occasions staff did not turn up at all.

We saw the times of calls on staff rotas did not always tally with what was in the person's support plan. For example, one person's care plan showed calls at 12.30pm and 8pm. We saw the care worker arrived at 12.45pm however their rota stated the call times were 2pm and 9pm. The care co-ordinator confirmed the call times were 2pm and 9pm and said these times had been in place since November 2013. The care co-ordinator told us that were unable to identify from the call systems they used when staff actually attended the calls. This meant people could not be assured of a consistent call time which meant the service was not organised in a way that was responsive to their needs.

The registered manager told us they had reviewed how double calls (where two care staff were required) were organised and this had addressed problems they were having. They said staff were contacted on a Friday so they knew who they were working with on the double calls. Staff we spoke with said this did not happen although it used to. They said their rotas did not always match or show if the call was a double call. They told us of a recent incident when only one staff member turned up to a double call. The service had no system to tell them when staff actually attended a call or if they arrived at the correct time. The office manager told us this information was recorded on the daily logs which were checked by them at the end of each month. This meant late or missed calls were not always identified or responded to at the time they occurred which put people at risk of not receiving care when they needed it.

Some people told us their regular carers were good but said there were frequently problems over the weekend. One relative said they had to visit several times a day after the care workers had been to check that their relative had received the care they needed. Another relative said, "It's very hard to get hold of staff on a weekend if staff don't turn up". We saw comments about staff arrangements on satisfaction surveys people had returned to the service, which said,

"Care workers arrive on time to their rotas which is not always the time I would like"

"Too many different carers coming, over last three weeks had nine different ones…timing is still hit and miss particularly at weekends"

"Not happy when carer came who was ill as they had been told no one else could cover"

Some people told us new staff were not always introduced and did not always know what support and care was needed. One relative said, "We had a new carer last night, they'd not been before so I had to tell them what to do. They were very nice but just didn't know us." Another

Are services responsive to people's needs?

(for example, to feedback?)

relative said,"If we have any new carers I have to let them know mum's needs. I feel this sort of information should be passed on and not left for me to do." Another person said, " I have to tell the new ones what to do. If new staff come they don't come with an experienced member of staff".

People's views on how well complaints were responded to by the agency varied. Some people told us they had raised several concerns in the past and it was only recently that they felt things had started to improve. One relative said, "The service in the beginning was abysmal, but it's better than it was and I feel things are dealt with now." Another person said, "Concerns tend to be dealt with". A relative said, "I know who to ring in the office and they usually sort things out".

Other people told us they were still experiencing problems. One relative said they had received a letter responding to their complaint but they felt the response was poor as it provided limited information. Another relative told us although they had received an acknowledgement letter in response to their complaint they had not received a final outcome letter.

Are services well-led?

Our findings

The service has a registered manager who is also a director of the Company that owns the agency. We found management and leadership of the service required improvement. The registered manager told us they led the service and had a team of five office staff to support them. We saw the registered manager worked alongside the office staff however we found they were not always informed or aware of issues we identified. We concluded the systems in place for monitoring the quality of the service were not effective.

The registered manager told us satisfaction surveys had been sent out in March 2014 to people who used the service. We reviewed the surveys which had been received back and found almost half of these raised issues about how the service was run. The common themes were new workers not being introduced, care workers not arriving on time, not knowing who the manager or field care supervisor were or how to contact them, staff not wearing ID badges or uniforms, people not receiving care reviews and people not aware of the complaints policy. One survey said neither the field care supervisor or manager had been in touch since the service started. We saw from the records this person's service started in November 2013.

We asked the registered manager what action they had taken since receiving the surveys. They told us they were not aware of any issues as the surveys had not been reviewed. They said they were waiting for all the surveys to be returned before they reviewed them. This placed people who used the service at risk as issues raised had not been reviewed or acted upon.

We found concerns that had been raised by people were not always investigated thoroughly. For example, we found certain staff members had been excluded from calls and the reasons why people had not wanted staff to attend had not been explored. This meant concerns about staff practice or potential safeguarding could be missed which placed people who used the service at risk from unsuitable staff.

We saw the office manager completed weekly monitoring reports which included details of any missed or late calls, safeguarding and complaints. The registered manager told us they had introduced the reports in January 2014 as a means of monitoring the service. They confirmed they received these reports and discussed the contents with the office manager. We found information on these reports did not accurately reflect what was happening in the service. For example, one complaint showed four missed calls between 17 and 21 March 2014, yet the weekly report stated only two calls had been missed that week. Another complaint showed a missed call on 24 March 2014, yet the weekly report for that week stated there were no missed calls. This showed the monitoring systems in place were not effective or reliable.

The registered manager told us the service was 'on top of complaints'. They said minor concerns were acknowledged and responded to and the office manager oversaw all the complaints. We found four complaints had been made and there were no records to show how these had been investigated or responded to. In one example, the office manager told us recent concerns had not been recorded as a formal complaint as they had been raised a few months earlier and had been dealt with then as a formal complaint. The office manager told us the concerns had been dealt with as a telephone complaint and were therefore not recorded formally. This was not in accordance with the agency's complaints policy. This meant there had been a breach of the relevant legal regulation (Regulation 19) and the action we have asked the provider to take can be found at the back of this report.

We also found an incident that had been reported to the police when a person went missing. This had not been notified to the Care Quality Commission as legally required. We discussed this with the office manager who told us they did not know this needed to be reported.

Many of the people and relatives we spoke with did not know who the registered manager was and said they had not had any contact with them. One person said, "I don't know (the registered manager), I have never had contact." Another person said, "I don't know who (the registered manager) is."

The office manager told us 'spot checks' were conducted on staff as they worked in people's homes to make sure care and support was being delivered in line with the agreed care and support plan. We saw evidence 'spot checks' had been carried out.

We found leadership was poor at all levels. There was a lack of organisation and poor communication between all staff which impacted on the service people received. For

Are services well-led?

example, the registered manager told us one of the office staff had been allocated the job of reviewing and updating all the care records. When we asked how this had been organised the registered manager said the staff member was working through them alphabetically. This did not recognise that some records may need to be prioritised due to people's needs. The satisfaction surveys had been opened and put in a folder by a staff member but no one had looked at them or reviewed them. Weekly reports were recorded but there was no evidence to show the learning gained from complaints, safeguarding and incidents or how this was shared with staff to ensure improvements in the service. This meant there had been a breach of the relevant legal regulation (Regulation 10) and the action we have asked the provider to take can be found at the back of this report.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Personal care	**Regulation 10(1)(b) HSCA 2008 (regulated activities) Regulations 2010** The registered person did not regularly assess and monitor the quality of the services provided in carrying on the regulated activity by, identifying, assessing and managing risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Personal care	**Regulation 19(1)(c) HSCA 2008 (regulated activities) Regulations 2010** The registered person did not have an effective system in place for identifying, receiving, handling and responding appropriately to complaints and comments made by service users, or persons acting on their behalf. The registered provider did not ensure any complaint is fully investigated and, so far as is reasonably practicable, resolved to the satisfaction of the service user or the person acting on the service user's behalf.

Regulated activity	Regulation
Personal care	**Regulation 11(1)(a)(b) HSCA 2008 (regulated activities) Regulations 2010** The registered person did not make suitable arrangements to ensure that service users are safeguarded against the risk of abuse by taking reasonable steps to identify the possibility of abuse and prevent it before it occurs and respond appropriately to any allegation of abuse

Regulated activity	Regulation
Personal care	**Regulation 9(1)(a)(b)(i)(ii) HSCA 2008 (regulated activities) Regulations 2010** The registered person did not take proper steps to ensure each service user is protected against the risks of receiving unsafe or inappropriate care by carrying out an assessment of the needs of the service user and planning and delivering care in a way that met the service user's individual needs and ensured the service user's welfare and safety.