Premier Care Limited

Premier Care - Bradford Branch

Inspection report

4 Commercial Street
Shipley
West Yorkshire
BD18 3SR

Tel: 01274584202
Website: www.prem-care.co.uk

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09 July 2018
10 July 2018
19 July 2018
24 July 2018
25 July 2018
27 July 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 9, 11, 19, 24, 25 and 27 July 2018. We gave the service short notice of our visit to the office base to make sure the registered manager would be available.

Premier Care – Bradford is a domiciliary care agency. It provides personal care to people living in their own homes in the community. It provides a service to adults and older adults. CQC only inspects the service being received by people provided with 'personal care.' At the time of the inspection the service was providing support to a total of 95 people, 30 of whom were receiving personal care.

This was the first inspection of the service since it was registered in August 2017.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Although staff could tell us about safeguarding procedures, we found incidents were not always being reported to the local authority safeguarding team. This left people at risk of receiving unsafe care.

Safe staff recruitment procedures were in place. Staff were given training, however, checks to make sure they were applying this to their practice were not always sufficient. This led to people not always receiving the care they wanted or needed. We made a recommendation about checks on staff practice being more robust.

Staff rotas were not always well managed and some people were dissatisfied with the times of their calls as care workers were often late. We have made a recommendation about reviewing staff rota's to make sure calls are made at the right times.

Medicines were not always managed safely. We made a recommendation about making sure the new medicines procedure was implemented and checks made to make sure it was being adhered to.

People had care plans in place, however, these were not always up to date or being followed by care staff. We made a recommendation about care plans being kept up to date and about staff needing to follow the care plans.

People who used the service and relatives told us the names of some staff they felt were good.

Three out of the five people who used the service and five out of the six relatives we spoke with raised concerns about the service. We found people's complaints were not always responded to. We made a recommendation about staff who are dealing with complaints having additional training to make sure

complaints are documented and responded to.

There was a lack of leadership and direction for staff, with no oversight of risks or key issues regarding people's care. Systems and processes for monitoring the quality of the care provision needed to be improved.

Feedback from people who used the service was being sought by the provider.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely. Arrangements for managing people's medicines needed to be improved.

Safeguarding procedures were not always being followed which left people using the service at risk of harm.

The management of staff rota's needed to improve to make sure people got their calls at the right times.

Is the service effective?

Requires Improvement

The service was not always effective.

Care workers received training, however, people using the service felt care workers were not always sufficiently trained. The procedures for checking on care workers' practice needed to improve.

People's nutrition and hydration needs were documented in care plans. However, staff were not always following the care plan.

If people were unwell care workers made arrangements to contact their relative, GP or district nurse.

Is the service caring?

Requires Improvement

The service was not always caring.

People who used the service named some staff they found kind and caring, however, their experience was not consistently good.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Complaints were not always responded to.

People's care plans needed to be up dated as people's needs

changed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A registered manager was in place who did not always provide effective leadership and management of the service.

The systems in place to monitor the quality of the service were not always effective.

Premier Care - Bradford Branch

Detailed findings

Background to this inspection

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

This inspection took place on 9, 11, 19, 24, 25 and 27 July 2018 and was carried out by one adult social care inspector and one assistant adult social care inspector. On 9 and 19 July 2018 the adult social care inspector visited the office base in Shipley. Both days were announced as we needed to make sure the registered manager was available.

Before the inspection we reviewed the information we held about the service. This included notifications from the provider and speaking with the local authority contracts and safeguarding teams.

On this occasion we did not request a Provider Information Return (PIR). The PIR is a document which gives the provider the opportunity to tell us about the service. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our visit to the provider's office we looked at elements of five people's care records, some in detail and others to check specific information, four staff recruitment files, medicines records and other records relating to the day to day running of the service, such as quality assurance checks.

On 11 July 2018 the assistant inspector spoke with four people who used the service and four relatives. The adult social care inspector spoke with four care workers, one co-ordinator, the administrator, care manager, registered manager and the head of governance. Two further relatives contacted us on 24 July 2018 to make us aware of their concerns. On 25 July 2018 we spoke with a social worker who had sent us some

information, a district nurse and another relative. On 27 July 2018 we spoke with another person who used the service.

Requires Improvement

Is the service safe?

Our findings

Safeguarding procedures were not always being followed to ensure people were kept safe from abuse and improper treatment.

Relatives made the following comments, "We have decided today we don't feel safe with the company anymore." "We have had a couple of missed calls on occasions, we weren't informed, one was a bedtime critical one."

We found incidents had been recorded on the contact sheets which should have been reported to the Bradford safeguarding team. For example, missed calls and a medicine error.

The district nurse we spoke with told us one person they supported had been admitted to hospital and had been discharged within 24 hours. This person was supposed to have four calls a day from the service. Carers visited once when they were discharged from hospital. Then three calls were missed. The person was found by the 'meals on wheels' person slumped in their chair the following day. The person was then admitted to hospital. The missed calls meant care workers had not checked on this person's health and welfare.

The same district nurse told us they supported one person who was an insulin dependent diabetic. Care workers from the service were supposed to visit in the morning to check the person had eaten. However, on 21 July 2018 the care worker did not turn up until lunchtime and the person had not had any breakfast. For diabetics missing meals can throw off the important balancing act between food intake and medication. The result is blood sugars that are too low (hypoglycaemia) or too high (hyperglycaemia) which is dangerous to a person's health.

On Sunday 22 July 2018 the district nurse we spoke with was visiting another insulin dependent diabetic. They told us care workers usually attended this call between 7:30am and 8:00am. At approximately 9:00am the district nurse telephoned the service to find out where the care worker was. The member of staff who answered the call said they were running three hours late because someone had telephoned in sick. After the district nurse explained the necessity of the visit the member of staff said they would make this person's call the next one.

The same district nurse told us a continence aid had been prescribed for one person on 5 June 2018, which would allow them more dignity. Arranging staff training with the district nurse had been unsuccessful This meant the new continence aids were still not being used when we spoke with the nurse on 25 July 2018.

We saw an entry on the 'client contact log' where a care worker had put oral medicine into someone's eyes. The care co-ordinator had taken appropriate action, however, no safeguarding referral had been made.

Staff had completed safeguarding training and told us they would report any concerns to a senior member of staff, the care manager or registered manager. However, the senior staff team were not always making referrals to the safeguarding team.

The above demonstrated a breach of Regulation 13, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received information during the course of the inspection and made seven safeguarding referrals to the local authority. One of these referrals was actively pursued by the safeguarding team.

The service did not always have an effective system to ensure there were sufficient numbers of staff to meet people's needs safely and in a timely manner. We asked people about the service they were receiving and if they thought there were enough staff. The people who used the service and relatives we spoke with told us the following: "They seem a bit short of staff at the moment, there's no continuity, which I think would be good." "I think they have staffing issues at the moment, I don't think they know what they are doing." "It started off between nine and half past [calls], if they are here now before 11am they've done well. By the time they [staff] get here I've been washed and done my pills. I get dressed, it's hard but I do it. The times are not consistent."

The care manager told us time was built in between each call for travelling time. However, care workers told us this was not the case. We looked at the work schedules for two members of staff. We saw the finish times of some calls were the same as the start time of the next call. No allowance had been made for travelling time. For example, we used a 'route planning' tool which showed us the journey times between some calls were 12, 14 and 18 minutes.

We saw there was contradictory information about the times and lengths of calls. For example, in one person's care plan it stated their morning call was for one hour. On the staff rota the call was scheduled for one hour but in the notes, it stated the call was 45 minutes. We looked at the times care workers had logged in over a five-day period and saw the visits were taking between 41 minutes and 56 minutes. We asked the provider about the variation in the duration of call times. They provided some explanation as to why the call times varied and did not consider this was a cause for concern.

In another care file we saw one day the morning call was not made until 11:13am. The care plan stated this call should have been made between 9am and 10am. This meant there was a significant delay for this person who required the help of staff to get them up in the mornings.

We looked at the staff meeting minutes for June 2018 and saw the following recorded, "More staff are starting …so hours should not be so excessive." We asked the registered manager and care manager about this and what was 'excessive.' They explained there were two staff who chose to work long hours, between 60 and 65 hours per week. We looked at the shifts they had worked over a four-week period and saw they had worked an average of 63.56 hours a week. We saw in their recruitment files they had signed a form to opt out of the 48 hours maximum working time directive. There were no risk assessments in place regarding them working excessive hours. Following the inspection we were informed staff working hours would be capped at 60 hours per week.

We would recommend staff rota's are reviewed to ensure calls which are 'time critical' are prioritised and travel time is included.

Following the inspection, the provider sent us an action plan informing us staff rota's had been reviewed to ensure the planned times of visits reflected services users' needs and calls had been prioritised in relation to people's needs.

We asked people who used the service if staff assisted them with their medicines. One person told us, "Yes

they do. I do if they aren't short staffed, due to short staff on weekends. It [staff] comes later. If they are later I get me neighbour to come down. Open me curtains and that and, they give me dossett box [with medicines in] and that, and neighbour will put them back in kitchen."

Medicines were not always managed or administered safely. The service had a medicines management policy which was not being followed by staff. The policy stated, "Premier Care will, where available, obtain the following information prior to any involvement and keep it up to date." The information required included the following, "A list of medicines the person is currently taking, including name, strength, form, dose, timing and frequency and what it was taken for." National best practice guidance also emphasised the need for this.

We saw on the medication administration records (MARs) details of each individual medicine had not been recorded. The MARs just stated 'Dosette box' and staff had signed the records to show they had given people the contents of the dosette box which had been dispensed by the pharmacist. This practice was not in line with the service's own policy which stated, "The MAR will include details of each medicine that the person is taking. It should include any specific instructions about how the medicine should be given."

Whilst it is acceptable for 'Dosette box' to be written on the MAR. A record of what medicines are in the dosette box must be available with the relevant chart. This is to ensure if the record has to be reviewed at a later date it is possible to identify what was administered. The provider told us a new medicines management policy was imminent.

We recommend the new medicines policy is implemented without delay and checks made to ensure it is being followed.

There was some information in the care plans about what medicines people were taking but not what they were for. The care manager produced a file with a list of medicines for one person, whose care plan we looked at, which was dated October 2017. We saw from this list they were taking one medicine which needed to be given 30 minutes before food. From reading the daily records we concluded this was not happening.

The same person had been prescribed paracetamol with two tablets to be given, four times a day. This medicine needed to be given with a four-hour gap between doses. We spoke with the person's relative who told us this did not happen. They also said there was an issue about the timings of other pain relief their relative had been prescribed. They made the following comment, "They [staff] don't seem to think its concerning about medication, [giving the] excuse 'our last call was cancelled'. Carers don't get paid between visits so they are just sat around waiting [when they do not have a call to make], not getting paid and want to get to them faster." We looked at one of the medicines administration records MARs for this person and found it lacked the necessary detail. This person was taking very strong pain relief, four times a day. There were no details recorded about how long there needed to be between doses. We could not determine from the MARs the times this medicine had been given. This meant we could not be assured this person's pain was being managed effectively.

The registered manager explained checks were made to make sure staff were competent to administer medicines. Two members of staff told us the medicines training was mostly about how to complete the MAR charts. However, we saw the training course they had attended had covered a wide range of topics.

Not enough had been done to mitigate risks to people who used the service who required support with their medicines. Medication risk assessments were in place, however, these were not always effective. A relative

told us about a recent incident they had reported to the service. The care worker turned up 11.35am for an 9am visit. The service had been contacted about the late call and the relative had asked them to treat it as the 12pm call. The care worker did not do this and gave the person their morning medicines and breakfast. The 12pm care worker arrived but did not read the care notes and gave the12pm medicines. The relative checked the documentation and saw two lots of tablets had been given. They consulted with the doctor, who said not to give the 4pm medicines. The guidance for giving this medicine states there should always be four hours left between doses as overdosing could cause serious side effects.

Following the inspection the provider told us action had been taken to ensure calls were made at the correct frequency to make sure medicines were given safely.

Records showed the necessary recruitment checks on new staff were made before they started working for the service. However, not enough was being done to make sure they understood fully what would be expected of them. For example, one person left the service whilst still on their induction period as they did not feel the job was right for them. Two staff had recently left the service after issues had been identified with their performance.

Assessments of people's homes were completed before a service was offered and were kept under review. These looked for any risks that may be present for people who used the service or staff. Where a risk had been identified action had been taken to reduce or eliminate that risk.

There were no risk assessments in place for the office base. The registered manager told us an outside agency were going to do this. We were concerned the service has been operating for nearly a year and this assessment had not been completed.

The service had an infection prevention policy and disposable gloves and aprons were available at the office base for staff to collect. One person who used the service told us, "One [member of staff] came one day without [enough] gloves, one glove on one hand and one in a plastic bag, that's the one that's not coming anymore, I mean how are you supposed to move and change someone with your hand in a plastic bag." We asked the care manager about this who told us there were always plenty of gloves available.

Requires Improvement

Is the service effective?

Our findings

People's nutrition and hydration needs were documented in their care plans. One person's relative told us care workers were supposed to leave their relative with drinks during the day and prepare them breakfast and lunch. They explained their relative would say to staff at lunchtime, "My daughter will get my lunch," but this was not the case. We saw from the daily records there was one day when they were not left anything for lunch. The care worker had written in the notes, "[Name] said they wanted their relative to make their lunch." There was also nothing documented on the daily records about care workers leaving them drinks in the morning, as detailed in their care plan.

We recommend care workers always follow the care plan and complete the daily records to confirm they have done so.

The registered manager explained new care workers without relevant qualifications were required to complete the Care Certificate. This course aims to equip health and social care support workers with the knowledge and skills they need to provide safe, compassionate care.

The registered manager told us new staff completed three days of training and then worked with a senior care worker for three 'shadow' shifts so they could get to know the people they will be supporting. We were told this time could be extended until the care worker felt confident to work alone. However, one person who used the service told us, "When someone new [member of staff] has come in they usually send someone that has been before to show them how to go on, but this person came on their own one morning, they didn't try really."

Spot checks were undertaken to check the competency of staff, however, despite these we still received the following comments from people using the service and relatives. A care worker speaking to a person who used the service like a four-year-old and a care worker not following the care plan. One relative said, "A lot of staff [are] brought in and not trained to do what they have to do. They didn't know how to turn [Name] properly, didn't know what they were doing to avoid bed sores. On care package to be turned [repositioned] and no one's trained." "I don't know that they have enough training. Some of them are very good, some of them are lacking to say the least.

We would recommend more robust procedures are put in place to check care workers practice.

Staff were provided with an introduction to end of life care training on induction. The registered manager told us additional 'end of life' training was being arranged for staff. They told us staff could 'opt out' of this training as not everyone could deal with discussions about end of life care.

Care workers we spoke with told us the training on offer was good. One person said they thought the induction training needed to be longer. We looked at the training matrix and saw care workers were being provided with relevant training.

Staff we spoke with told us they received supervision and felt the office staff were approachable. Supervisions were 'face to face' or in the form of a spot check of their care practice in the community.

Care workers' told us in an emergency they would contact the emergency services. If someone needed a visit from a GP or district nurse they would contact the office staff who would arrange this and/or speak with relatives.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. For people living in their own home, this would be authorised via an application to the Court of Protection.

We found some relatives had signed some consent to care documentation on behalf of the person. We were told this happened when the person was physically unable to sign.

The care manager told us they thought there was one relative who had a Lasting Power of Attorney (LPA) for property and finance. A LPA is a legal document that allows someone to make decisions for you, or act on your behalf if you're no longer able to. We recommend checks are made to establish what LPAs are in place so it is clear which relatives or representatives have the legal authority to make decisions.

Requires Improvement

Is the service caring?

Our findings

Confidential information about people who used the service was not always stored safely. We asked for all of the daily records for one person who used the service and found some of the records were missing. The registered manager told us the head of governance had them, however, when we spoke to this person they told us they did not have these records. The provider did give us a potential reason why the logs were missing.

We were told about a previous incident, which had been investigated by the provider. This was when confidential information about someone who had used the service had been left in a file that was placed in another person's house. We asked the provider to consider if these incidents needed to be reported to the Information Commissioner's Office. They did this and established this was not necessary.

One person told us they did not want male carers, but said the office kept sending them. "I just don't want different men coming into my house. Twice a man's come in and come upstairs at half past six and he's put his head round the door and I've asked what he wants and he said he'd come to wash and change me. I rang office and to say I didn't want a man, [a member of office staff told me] 'they're all trained' but I said I don't want different men." We looked at the service's policy which stated, "If a service user has expressed a strong preference that they receive personal care from a care giver of either the same sex as themselves or the opposite sex, then as far as possible we will provide this service within the resources available."

A relative also told us, "[Relative] has three calls a day. We have constantly asked for a female carer and the care plan states, 'female carer requested.' We only had one female carer come in and then she stopped coming. Relative needs help with personal care and wanted a female carer for their dignity." This issue had not been dealt with by the registered manager.

The care documentation had the provision to record information about people's cultural and religious needs. However, this had not been completed in the care files we looked at. In one person's care file it stated they spoke 'Urdu.' However, we saw at a review meeting it stated they would prefer Punjabi speaking carers. We asked the care manager about this and they could not tell us which language was correct. We spoke with two care workers who told us they spoke Punjabi with this person.

The service's 'Equalities training' gave staff a lot of information such as, family values, naming systems, awareness of festivals, ceremonies, religious celebrations and dietary considerations such as forbidden foodstuffs. None of this information had been documented in people's care plans.

We recommend improvements are made to the documentation of people's preferences, cultural or religious needs, together with details of how they will be met.

We asked people who used the service and relatives what they thought of the care workers. These were some of the comments people made, "Like everything there are some good some bad. There are some we wouldn't have again, but the ones that come at the moment are alright, nice." "We can have a laugh and

joke. Yes, I can take mickey out of them and we always end up laughing." "The lad who's coming now, he's got to be regular, he's confident, he's very good." "One of them has left now because they spoke to me like a four-year-old and I didn't get apology when I asked office." "Some of them are lazy."

People who used the service and relatives spoke well of some individual care workers telling us they were kind and caring. Care workers we spoke with knew people well and explained how they maintained people's privacy and dignity. One care worker said, "They are lovely people we support. Our jobs make a difference in their lives."

Requires Improvement

Is the service responsive?

Our findings

Complaints were not always responded to. The complaints procedure for the service was detailed in the 'service user guide,' which the provider told us was given to every service user. However, one relative told us they had not seen the complaints procedure and only had the office number and an email address. One person who used the service told us, "You'll put a complaint in and they'll say leave a message because I'm just manning the phones or call Monday morning and we'll get back to you. They're a shambles." Another person said, "I tried it [making a complaint], and I've stopped. I phoned in. Funnily enough someone gave me a Manchester number, we can do nowt love. Wrong number. Tried to ring Bradford? No response at all." The provider accepted some people who used the service may have had difficulty in contacting the office.

A social worker told us one person who used the service had telephoned the office and made a complaint about one of their care workers. This complaint had not been logged and the person using the service received no response. The social worker contacted the service to make the complaint on behalf of the client. They were not offered a copy of the complaints procedure; however, the complaint was taken verbally over the telephone. Again, this complaint was not logged.

Another relative told us, "Regularly [Name of care manager] will advise that she is not aware of previous concerns and when we met with them they advised us that records of the complaints we had previously raised verbally had not been kept properly by previous managers."

The Bradford local authority commissioning team had sent four complaints to the service to be investigated. We looked at these and found one of the responses had been very poor. The complaint had been about the support being offered to one person who had used the service. The complaint record showed this had not been properly investigated as one care worker was on sick leave, another had left the service and there were no daily log books available. We spoke with this relative who was adamant the daily log books had been collected by a member of staff.

We recommend staff who are dealing with complaints have additional training to make sure complaints are documented and responded to, in line with the provider's policies and procedures.

Following the inspection the provider sent us an action plan telling us how they were going to improve complaints management at the Bradford branch.

Care was not always delivered as required by the care plan. A relative told us their family member's continence needs had not been met on one occasion as when they saw them at tea time they were very wet. We looked at the daily records for the day in question which confirmed this was the case. We saw prior to this incident care workers had written in the daily notes the person was struggling to stand with the assistance of one care worker, yet no reassessment of their needs had been undertaken.

One relative told us, "I ring the service nearly every day to find out where the carers are. I always give them 15 – 30minutes leeway for them to be late first. It causes my relative a lot of stress when the carers are late. A

key safe was organised but carers still rang to be let into the building and my relative had to drag themselves to the telecom to allow them entry. Carers are not reading previous notes on the daily logs or instructions left by the family. For example, we left notes about antibiotics being given, but these were ignored by carers. We asked carers to make a light lunch of a sandwich or soup but they make a large meal."

The care manager told us no-one was currently receiving end of life care. None of the care plans we looked at had any information about people's end of life wishes.

Care plans were functional and gave a series of tasks which need to be completed at each visit. There was very little recorded about people's individual preferences, likes and dislikes. Care workers told us if people's needs changed they would tell the office staff and arrangements would be made for people's care packages to be reviewed. However, we found this was not always the case.

We recommend care plans are updated as people's needs change and systems are put in place to communicate any changes to care workers.

The care manager explained when a new service was requested one of the senior team would arrange to visit the person and their relative. Risk assessments would be completed and a care plan agreed.

People who used the service and/or relatives had signed documentation in the care files to confirm they had been involved in the assessment and care planning process. One relative told us they had been involved in the initial assessment process.

We looked at what the service was doing to meet the Accessible Information Standard (2016). The Accessible Information Standard requires staff to identify record, flag and share information about people's communication needs and take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it.

We asked the registered manager for their accessible information policy, they contacted the head of governance as they did not know if there was one. We spoke with the head of governance following our second visit to the service and they told us they were in the process of preparing a policy.

Requires Improvement

Is the service well-led?

Our findings

The service was not always well-led. There was a registered manager in post, who also managed another service for the organisation. They explained the care manager was taking over the management of the Bradford branch once registered with CQC. We spoke with both managers and found neither had an overview of the service. Telephone calls to the office were mostly taken by the administrator or care co-ordinator and logged onto the computer system. The registered manager and care manager did not have oversight of the information which was coming into the office. A new system was introduced to ensure the registered manager and care manager were aware of all the calls which were coming into the office.

The registered manager had been in post since the service opened in August 2017. The care manager was the third person to hold that position. A new administrator had also started work in April 2018.

Complaints and concerns were not being analysed to see if there were any common themes or trends. We asked the registered manager about this and they told us complaints were 'pulled through' on the computer system and into a report. However, when they found the relevant document complaints were not a feature of the report.

The provider completed audits of the service against the regulations. We saw their report from April 2018 which had identified, for example, issues with medicine management. It also identified the issue with medicine management had been raised at the previous visit in October 2017. The registered manager told us they had not seen this report. They said the previous care manager had been present when the provider visit took place. The report gave details of issues raised, who was responsible for making improvements, what needed to be done to 'make improvements happen' and a date. We asked the registered manager if the date given was when improvements needed to be completed by and they said they did not know. We spoke with the head of governance who said the improvements should have been made by the date indicated on the report. The date given in relation to medicines management was 31 May 2018.

There was a MCA and DoLS policy in the policy folder, however, this was only relevant to a residential service. The care manager told us they printed off the policies so staff could refer to them. If they had read the policy and understood the legislation they would have realised that policy was not relevant to a domiciliary care service.

A relative told us they had complained about a care worker's behaviour and did not want them to continue with visits. They were told no other care workers were available and the care worker they did not want continued with the visits. We spoke to the registered manager who agreed the care worker should have been suspended from duty whilst the complaint was being investigated.

The administrator explained they had a lead role in relation to recruiting staff and interviewing potential care workers. The up to date recruitment and selection policy did not contain information about which staff should be involved in the interview process.
The above demonstrated a breach of Regulation 17, Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Some telephone surveys had been completed by the care co-ordinator but these did not identify any particular issues. The provider sent us survey information which had been obtained by head office staff. This meant feedback from people about what the service was being sought.

Staff meetings were held. We saw the meeting minutes for June 2018 and saw there were concerns about an increase in staff sickness. One care worker told us staff morale was low and staff were working long hours. Staff were thanked for helping out to cover sickness. There were no discussions about policies/procedures, best practice or any ideas for improving the service.

The registered manager was working in partnership with Bradford local authority and was providing a 'Rapid response' service to people who needed a temporary service until a permanent provider could be found.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not being operated effectively to investigate allegations or evidence of abuse. 13 (3)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated effectively to monitor, assess and improve the quality and safety of the services provided and ensure compliance with regulations. 17(1)(2)(a)