SOS Homecare Ltd

SOS Homecare Limited - Statham House

Inspection report

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Date of inspection visit:
08 March 2016
10 March 2016
14 March 2016

Date of publication:
29 June 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 8, 10 and 14 March 2016 and was announced. We gave the provider 48 hours' notice of our intended inspection to ensure that the interim manager or a representative would be available in the office to meet us.

The previous inspection had been conducted on 18 September 2014. At this inspection, we found that the service was not compliant in ensuring that people using the service received safe and appropriate care that met their needs. We told the provider to take the appropriate action.

SOS Homecare Limited – Statham House (SOS Homecare Limited) is a domiciliary care agency in Manchester which provides personal care to adults within their own homes. Care is provided for people with a wide range of needs across areas including Sale, Urmston, Flixton, Timperley and Trafford. There were about 170 people receiving services from SOS Homecare Ltd during the time of our inspection.

At the time of our inspection, SOS Homecare Ltd did not have a registered manager. 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 were told by senior management that the service had suffered as a result of this. The provider had temporarily appointed an interim manager who was registered at one of its other locations. This interim manager had been in post since mid-November 2015.

We found breaches in the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014. You can see what action we have told the provider to take at the back of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from

operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

There had been a high number of missed and late visits to people using the service in the last 12 months.

Risk assessments we looked at did not always document explicitly what actions were required by staff to mitigate risk. In some people's care files, we also saw no evidence that risk assessments which should have been undertaken had been done.

Overall, people told us they felt safe with the care staff that supported them. Staff we spoke with were knowledgeable in the principles of safeguarding people and knew how to report any allegations of abuse that arose.

We did not see any evidence that the service had done mental capacity assessments for those people using the service who lacked capacity. We were told that the service used the mental capacity assessments and best interest decisions that had been completed by the local authority.

People expressed confidence in their care workers' skills and experience though some people did raise concerns about less experienced staff members. Since May 2015, SOS Statham House had implemented the "Care Certificate" for induction training for newly recruited staff. The training manager spoke passionately about developing new courses which would be suitable for the domiciliary care industry in which the organisation operated. We also saw initial course outlines for two new subject areas of Stoma Care and Catheter Care.

In the main, people and relatives thought that care staff were kind and caring. People and their relatives told us they had been consulted in the care planning and decision making process regarding the support they received and felt their opinions were considered by the service. Staff we spoke with gave us examples of how they encouraged people to maintain their independence and that people were able to make choices about the daily care and support they received.

Care records we reviewed contained insufficient details regarding people's individual outcomes and personalised descriptions of their care and support. We saw as well that actions to reduce risks to people were not always specific to the person's needs in that there were directions to staff but no detailed reference to how their actions would mitigate the risk posed to the person.

Some care plans were missing information or contained contradictory information which meant that staff may not always have sufficient or the most accurate information to guide them and support people appropriately.

The service had an up to date complaints policy and procedure. People we spoke with were aware of this and told us they would use it if the need arose.

The provider had quality assurance systems in place but was unable to demonstrate how the service had improved on quality as a result of analysis and lessons learnt. The lack of regular and systematic analysis and clear actions meant that the provider was not effectively monitoring the quality of the service. People

told us that they were able to give feedback to the service about the support they received. Some said that they had completed an annual quality survey.

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.

Staffing levels were inadequate for the number of people supported; this had an impact on the timing of care visits to people with the majority of people we spoke with saying that they had experienced late and missed visits.

Risk assessments did not always give clear and specific guidance as to how staff should manage people's risks.

People told us that they felt safe when their care staff were visiting and said positive things about how staff made them feel safe.

Is the service effective?

Requires Improvement

The service was not always effective.

The service did not carry out its own capacity assessments on people known or suspected to lack mental capacity.

Some people told us they had confidence in their care workers' knowledge and skills. However some people had concerns about the capability of some of the care workers that supported them.

There was a good in-house training team which provided mandatory and other training opportunities to staff. Staff however did not have regular supervision meetings and professional development discussions.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us that the high turnover of staff within the service meant that not all carers knew them well or understood their needs.

Care staff we spoke with adequately demonstrated their understanding of how to maintain people's dignity and independence.

People and their relatives told us they thought care staff the care staff who visited them were kind and caring.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The care plans we reviewed lacked details for some people's individual outcomes and personalised descriptions of their care and support routines.

People's care plans were in the process of being updated; these new plans were detailed and person centred including summaries of people's life history and the people who were important to them.

The service had an up to date complaints policy and procedure which people told us they knew about and would use if required.

Is the service well-led?

Inadequate

The service was not well led.

At the time of this inspection the service did not have a registered manager in post and the service had had some upheaval over the past four months due to the lack of day to day management.

There was a system of quality checks and audits in place but this did not effectively monitor the safety and quality of the service.

People and relatives we spoke to felt that the service was well managed but that there were some limitations such as the need for more care staff and better timing of visits.

SOS Homecare Limited - Statham House

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.

The inspection took place on 8, 10 and 14 March 2016 and was announced. We gave the provider 48 hours' notice of our intended inspection because the location provides domiciliary care service; we needed to be sure that a manager or a company representative would be available in the office to meet us.

The inspection team consisted of two adult social care inspectors and one bank inspector. Before our inspection, we reviewed information the Care Quality Commission (CQC) held about the service including safeguarding notifications and complaints. We contacted Trafford Council Commissioning team for information they hold about the service; they told us they had concerns about the high number of safeguarding referrals for missed and late visits that they had received for this service. We contacted the NHS Trafford Clinical Commissioning Group (CCG); they told us that they did not have any issues with this provider. We also contacted Trafford Healthwatch who told us that they had not received any feedback about this service. Healthwatch is an organisation responsible for ensuring the voice of users of health and care services are heard by those commissioning, delivering and regulating services.

A Provider Information Return (PIR) had not been requested. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we spoke with four people using the service and seven relatives who had agreed to speak with us. We spoke with eleven staff members including the interim manager, the quality manager, an administrative officer (responsible for human resources issues), three care workers and the managing director, who was also the nominated individual. A Nominated Individual is a person employed as a director,

manager or secretary of an organisation with responsibility for supervising the management of the regulated activity. We reviewed eight people's care files and ten care staff personnel files. We also spoke with a social worker who had involvement with the service. We reviewed the service's operational documents such as its statement of purpose, policies and procedures, training records, senior management meeting minutes, quality reports and business continuity plans.

Inadequate

Is the service safe?

Our findings

We asked people using the service and their relatives whether they felt safe when the care staff were visiting. Most people and relatives had positive things to say. They said, "Yes, (I feel) very safe; the girls are great, cheerful and we have a laugh", "Yes always but I always ask to see their identity card", "Safe? Very, they have just done the tea time call", "Yes, I feel safe with the carers and if I didn't I would tell them face to face because I am comfortable talking to them" and "My relative feels safe with his carers; (person's name) would say if (they) didn't."

We asked people and relatives if they received support from the same care worker or same group of workers. Some people told us that they were visited by different care workers but that this group of staff was consistently the same. However, two people told us that this was not always the case for them and also that the service had not informed them before a new care worker visited. Another person using the service told us there was a high turnover of staff but that there were a few care workers who had been with the service for a long time. This meant that people were not likely to know all of their care workers well and that could potentially affect how safe they would feel.

Staff we spoke with demonstrated that they knew how to keep people safe and gave us examples of how they did this such as making sure the person's environment was free from trip hazards and that doors were closed and locked appropriately. Staff we spoke with told us they had done safeguarding training. Most were able to give examples of types of abuse and knew what steps to take to report allegations of abuse.

The training records we reviewed showed that staff had received safeguarding training and were automatically scheduled to undertake an annual update. The interim manager told us that staff who had not done this training had either been rescheduled for another date and removed from the work rota until they had successfully completed the training. However when reviewing the staff rotas we identified staff who had not been removed. This potentially posed a risk to people using the service.

At the last inspection in September 2014, we found that the call times fluctuated significantly and that people were receiving their care outside of the agreed time frames for service delivery. We looked to see if this issue had been rectified since our last visit. We contacted the local authority commissioners to see what information they held about the service and if they had undertaken any remedial action. The commissioners told us they had received 119 safeguarding referrals for missed and late calls to people for the period 1 April 2015 to 1 March 2016. People received services such as personal care, help getting out of bed and being put to bed, meal preparation and medication administration. This meant that people were potentially put at risk because their care workers were either late or did not turn up. The commissioners informed us that they were in the process of developing an action plan to address these concerns and would be working with the service to improve the quality of service provided.

We were notified by the service and the local authority about an incident in February 2016 where 16 people had not received their visits from care workers. The interim manager told us and we saw that the incident had been investigated thoroughly and appropriately. People affected received an apology from the service.

One staff member had been dismissed and the other had received disciplinary action in accordance with the service's policy. We asked the interim manager what action had been taken to eliminate or minimise the recurrence of this incident. They told us that care staff had to call into the office to let them know that they had started their shift. We did not see documentary evidence of how this had been communicated to staff. This meant we could not be sure that these prevention measures would be effective or sufficient to reduce the incidence of missed or late visits.

The majority of people and relatives we spoke with told us that they had experienced missed or late visits. We asked the interim manager about this in relation to the staffing levels. The service employed 79 care staff. They told us the service had experienced a lot of staff sickness over the last three months and that they were currently recruiting new staff. We noted from the training records that a significant number of staff was new to the service; a third of the staff had been recruited in the last three months, December 2015 to February 2016.

The number of missed and late visits and a lack of adequate staffing levels constituted a breach of Regulation 12(1) HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

We reviewed the service's safeguarding log which had not been completed correctly. For example, some entries had no initials so we could not tell which member of staff had completed the entry; there were no actions documented over a three-month period January to March 2016 so we did not know what action had been agreed and taken. We also saw in this document that the source of referral column had been incorrectly completed with a date inserted rather than a person's name or job role and there were errors in dates. Failure to have systems and processes in place to effectively investigate, manage and notify any allegation of abuse is a breach of Regulation 13(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 Safeguarding service users from abuse and improper treatment.

We saw that risks to people using the service were recorded in their care plans but did not always provide specific instructions on how staff should manage the risk. Risk assessments should provide clear guidance to staff and ensure that control measures are in place to manage the risks a person may experience. Examples of risk assessments included moving and handling, abuse protection, cooking and food storage, and environmental factors. In two people's care plans, we saw that risks had been identified but that these had not been explicitly documented in their risk assessment or had not been risk assessed at all. In one person's file, we saw that they needed 'thickener' medicines. Thickener medicines are added to drinks, and sometimes to food, for people who have difficulty swallowing; they may help to prevent a person from choking. We did not see specific information to guide staff on how to use the thickeners or the consistency required for that person. We checked the person's medication administration record (MAR) which also provided no specific details. There was also no evidence that a swallowing or choking assessment had been done. In another person's care records, we saw that they were at risk of dehydration; we saw the following note documented in the care plan, "plenty of fluids to be given" but we did not see any evidence of how this risk was being monitored.

This meant we could not be certain that staff had sufficient information to guide them on how to reduce or eliminate the risk so that the people were kept safe. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment with reference to 12(2)(a)(b).

We raised these issues with the interim manager who assured us that they would address them and update these assessments immediately.

We looked at the service's recruitment processes and spoke with two staff members responsible for recruitment and human resources. They told us that the service was "struggling with recruitment" and that "it (recruitment) was quite ongoing". They also told us that only one person interviewed prospective employees. During the inspection, we looked at ten staff personnel files to check how the service had recruited new members of the care staff team. We saw that staff files contained their application form including employment history, two written references, proof of identity documents and a criminal records check from the Disclosure and Barring Service (DBS); these records help to demonstrate that those people appointed to work had been assessed as having the qualities and skills required for the role. The DBS identifies people barred from working with vulnerable people and informs the service provider of any criminal convictions noted against the applicant. We noted that candidates' responses to interview questions were also documented but had not been scored. We reviewed the provider's recruitment policy which stated that candidates would be interviewed by a panel and that the interview should be scored. These issues did not comply with the service's current recruitment policy and procedure and also meant that there was no objective way to know that the most suitable person had been hired. This meant that the recruitment process was not as robust as it could be.

Where appropriate people using the service were supported to take their medication safely and this was documented on MAR sheets. We found that the MAR documentation was very comprehensive. Staff we spoke with were able to explain their role in administering medicines and how they documented what had been administered or when a person refused to take their medication.

We were told and we saw that care workers collected personal protective equipment (PPE) such as aprons and gloves from the main office. People confirmed that staff demonstrated awareness of good hygiene practices by wearing gloves and aprons. Staff training records showed that staff had received training in infection control; this training was up to date at the time of our visit and we saw the staff members who were required to update their training in this area. This meant that staff were demonstrating responsibility for promoting good and effective infection control in their work practices.

We looked at the service's incidents and accidents record and we saw that there had been four incidents or accidents in the last 12 months. We did not see any analysis of why the incidents had occurred, any precursors to the incidents, and the outcomes and consequences to demonstrate that learning had taken place across the service.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us that they had confidence in their care workers' abilities; they said they felt care workers had the necessary knowledge and skills to provide a good standard of care. Some of their comments included, "Yes, I have confidence in their ability", "They know what they're doing", "In the main, I have confidence in the carers" and "Staff have the right skills and are very good with [Person's name]."

However some people had some concerns about care staff's skills. One person told us, "Staff skills are okay" and another said, "I have confidence in 80 per cent of them (carers); some carers are good and some are bad but that is life…they are not taught properly." A relative told us that they did not think that all care staff had the necessary skills and added, "They (carers) are too rushed and too young". Relatives expressed concerns that care staff were not sufficiently monitored to ensure their competence to do the job.

People and their relatives told us that their care workers always asked for their consent and explained what they were going to do before doing the task. One relative told us that even though their family member could not respond because of the effects of a stroke staff still asked what the person wanted and talked with them throughout their visit.

Some of the people we spoke with told us that care workers supported them with meal preparation such as preparing toast for breakfast, making a sandwich or heating up a microwave meal. People consistently told us that staff always asked what they wanted and that their preferences and choices were respected.

Staff we spoke with told us that they had had an induction programme which they said adequately prepared them for care work. They told us their induction included mandatory training such as understanding their role and responsibility, privacy and dignity, moving and handling and health and safety. They also told us that they undertook shadowing shifts with experienced staff before they were validated to work on their own.

We saw that the service had implemented the Care Certificate for induction training since May 2015 for new staff joining the service. The Care Certificate is a set of standards to be worked towards during the induction training of new care workers; it helps care workers develop the values, behaviours, capabilities and skills needed to provide high quality and compassionate care. The Care Certificate is not mandatory, although services that choose not to use it must demonstrate that their induction of workers new to health and social care delivers similar outcomes.

The provider SOS Homecare Ltd had an in-house training team that provided classroom training which was complemented by E-learning. The training team was responsible for delivering all mandatory training, for example, moving and handling, infection control and health and safety which prepared staff to do their jobs effectively. The training manager spoke passionately about how they had adapted courses such as continence management and stoma care to be suitable for the domiciliary care industry they operated in. From the training records, we saw that staff had completed these courses. The training manager also told us about and we saw the development of more advanced courses in areas such as advanced dementia care,

palliative care, diabetes, and epilepsy. The training manager said these courses were being developed in recognition of the changing needs of people using their service; they were evidence that the service was responding by making sure their care workers were prepared. This initiative was endorsed by senior management who wanted other courses such as communication skills to be introduced. We were told that these advanced courses were not mandatory but care workers who wanted to progress within the company would be expected to have completed them.

Staff we spoke with said that the mandatory training prepared them to do their jobs effectively. One staff member told us that they felt the "basic training was adequate but training (in general) has improved over the years." Another staff member said, "I've learnt a lot over the years via experience and training. [Trainer's name] is a good trainer and … explains things really well." Staff told us that the service had a system of sending them reminder of any outstanding training they were required to do.

Care staff we spoke with said they had supervisions with their line manager at least twice a year. We reviewed ten care staff personnel files; three of these staff members had been recruited in mid-February 2016 and had not yet received supervision. We did not find supervision records in two care staff's files. The remaining files recorded that staff had received two supervisions and that there had been a gap of nine months, on average, between each session. According to the service's supervision record staff should have supervisions every three months.

Of the seven staff who had been employed with the service over a year, we noted six of them had had an annual appraisal. We did not find an appraisal for one member of staff and another staff member had not had an appraisal in over 15 months.

We saw records that some spot checks had been undertaken by care coordinators and senior care workers. We saw that not all staff had had a spot check in the last three months. The care coordinator we spoke with told us that spot checks should be done every six to eight weeks and at the moment were being done when a person using the service raised a concern or made a complaint. Spot checks are used by the service as an assessment of the staff member while on duty; they check whether staff arrived on time, used personal protective equipment (PPE), followed the correct procedure when administering medicines and communicated with the person they were supporting.

The lack of regular supervisions and appraisals and irregular spot checks on staff meant that we could not always be certain that staff's professional development needs were being met to enable them to carry out the duties they are employed to perform. This meant that there was a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

We looked at what consideration the service gave to the Mental Capacity Act 2005 (MCA) and checked whether the service was working within the principles of MCA. 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.

The service provided care and support to people who sometimes lacked capacity to make certain decisions for themselves. Yet, we did not see any mental capacity assessments on file for people considered by the service to lack capacity. We spoke to the interim manager and one of the care coordinators about this and they told us that mental capacity assessments and best interest decisions were done by the local authority. The interim manager told us that they would attend best interest meetings when required.

We noted in one person's care record that we looked at their family had been involved in making the decisions regarding their care however the person had mental capacity and had signed their care plan. In another person's care record, we saw that the person's consent form had been signed by their next of kin who had 'lasting power of attorney' for health and welfare decisions. This meant that the person had delegated the responsibility to their relative to act on their behalf. However when we reviewed their care records, we found no evidence to show this authority was in place. This information is essential to ensure that decisions made on behalf of people are lawful. We saw other examples of people's relatives signing care plans and consent forms where the person was said to lack capacity; but we did not see capacity assessments in these people's care files nor was there evidence that relatives had lasting power of attorney for them. We did not see any evidence that the service was acting in accordance with MCA 2005.

This was a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent.

Relatives told us that the service had supported their family members to access healthcare services if needed. One relative told us that the care staff "have telephoned for an ambulance straight away" when her family member experienced chest pains. A staff member confirmed that they would contact relevant health care professionals with the person's consent if they felt that was necessary. For example, one care worker said that they had noticed a pressure ulcer developing and had telephoned the office to arrange for a district nurse to visit that person. We saw in people's care records that the healthcare support they received had been documented and there was guidance for staff on how they should monitor and report any concerns they had.

Requires Improvement

Is the service caring?

Our findings

People's experiences with care staff were mixed. In the main, people and their relatives told us they thought that care staff were kind and caring and made positive comments about them. These included: "They are so nice. They make sure I've got everything before they leave", "Yes the ones I have I do think are caring. They are very friendly and caring", "What I like best about them is that I have an isolated life, they are smashing to me and part of my social network. They extend my life – marvellous", "They (care staff) chat with [Person's name] and everything is alright", "Yes, in the main, they are very kind and we can have a laugh with them" and "Staff will chat which I like".

Several relatives also told us that the care workers they had met were caring and respectful and that they had no reason to doubt that the care workers were anything but respectful towards their relation.

However, some people and relatives raised concerns about care staff's understanding of their needs. One person told us that there was a high turnover of staff within the service but that they had "four core long-term regular carers" that "know me inside out" and described these staff members as "very good" and "kind and caring". Another person we spoke with said that there were less competent staff who did not understand their needs. And a third person told us that new staff didn't always understand their needs until they got to know them. This meant that there was inconsistency in the levels of care and support that people received. The impact on people therefore depended on the care workers that supported them.

People spoke about their care staff getting to know them and that they would talk about various subjects such as what people had done during the day or tell each other jokes. During our inspection we spoke with three care staff; one had been recruited in mid-February 2016. The staff we spoke with were able to tell us about the people that they supported and said that they enjoyed getting to know them. One staff member told us their role involved forming relationships that were "friendly and objective but (maintained) professional boundaries". Another staff member told us that they would always try to find out about people's lives and interests so that they would be able to develop a connection with them.

We spoke with a social worker from the local authority who was currently working with SOS Homecare Ltd to safeguard a person using the service. They told us, "(SOS Homecare Ltd) have been so supportive of this (person); they look out for them and go above and beyond the call of duty." The social worker told us they had witnessed the positive impact that the visiting care staff had on this person. They said, "[Person's] face lights up when the carers come."

People and their relatives told us they had been consulted in the care planning and decision making process regarding the care and support received. They said that they were able to put forward their views and felt that these had been considered. People and relatives told us that they had a copy of their care plan and a communication book (in which care staff documented the tasks done at each visit). This meant they could check what was written in their care plans and the communication book.

However the number of people who had not received any care due to missed visits, the high turnover of staff

and the lack of person centred details in some people's care plans, for example, did not demonstrate the qualities of a caring service. This meant that whilst we heard positive feedback about individual care workers, the persistent failure of the provider over a long period to address the issues around missed visits and care delivery was not consistent with a caring service.

Some staff we spoke with told us how they encouraged people to maintain their independence. They told us people were able to make choices about what they wanted to eat, drink or wear. One care worker described how they encouraged people to be independent by letting them do as much as they could and only assisted if that was what the person wanted. This showed that people had choice and were able to make their own decisions.

People told us that they were treated with dignity and respect by their carer staff. One relative told us "[Person's name] has a complete strip wash every day; they (the care staff) close the curtains and have a little cloth/small towel that is moved only for washing purposes". One person using the service told us, "The carers treat me so much nicer than my previous ones (from another agency)". They told us that previous care workers from another domiciliary care agency "talked over (them)" and made offensive statements about their weight.

Staff demonstrated to us that they understood how to maintain people's dignity and treat them respectfully. They were able to give us examples of how they maintained people's privacy and dignity such as ensuring that bedroom doors and curtains were closed when performing personal care and getting people ready.

Requires Improvement

Is the service responsive?

Our findings

We reviewed care records for eight people using the service, the majority of which were detailed and person centred; we were told that the service was still in the process of updating some people's care files. This meant that the content and level of detail varied from one plan to the next. These care plans were an improvement on the care plans that we saw at our last inspection in September 2014 but not all of the care plans had been updated as required.

At our inspection in March 2016, we noted that the updated care plans contained summaries of people's life history, their preferences and the people that were important to them such as spouses and children, agreed visit times, gender preference of visiting care staff and relevant risk assessments including moving and handling and any identified environmental risks.

There were some care plans which did not have a completed personal history. In these cases, there was no information for care staff to get to know the person prior to visiting them. Only one of the care records we looked at had a photograph of the person. We asked about this and the interim manager told us that some people were not comfortable with having their photograph put into their care records. However there was no record of these conversations or decisions recorded to support this.

We also noted that there insufficient details in some people's individual outcomes and personalised description of their care and support routines. In one person's care record, their daily routine did not give any specifics about the person's meal preferences. We noted that the older-style care records had recorded this level of detail. We also observed in two other care records for different people that they had identical outcomes. In another person's care record their morning support routine had been duplicated in the afternoon one. We saw as well that actions to reduce risks to people were not always specific to the person's needs. In one person's care records it gave directions to staff but with no detailed reference as to how their actions would mitigate the risk posed to the person.

We saw that some care plans had inaccurate or missing information such as the level of risk assigned (low to high) to specific risks identified such as moving and handling and communication. This meant that there may not have been clear and sufficient information to guide staff providing the support.

These issues were a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person-centred care.

We highlighted all of these issues to one of the senior care workers and the interim manager who told us they would ensure they were addressed and updated as required.

The service had an up to date complaints policy and procedure which encouraged people to raise any concerns they may have about the service. People told us that they knew about the service's complaints procedure and would use it if required. Some people we spoke with said they never had cause to make a formal complaint or raise a concern. One person told us that they had never made a formal complaint about

the service but that they would speak with the "good carer" who passed the information on. A relative told us they made an informal complaint via telephone because of a missed visit and had received an apology from the service.

We looked at the complaints, comments and suggestions log kept by the service. Overall 26 informal and written complaints had been logged between March 2015 and February 2016. The majority of these were about the timing of people's visits and missed and late calls. We saw that complaints had been received from social workers and healthcare professionals. We noted that the complaints log was not well organised; complaints were not in chronological order and had been logged on separate sheets. We could not always tell what action, if any, had been taken to address the concerns people had raised. We also did not see evidence of any trends identified or analysis done for the complaints that had been received. So we could not be sure that the service had a systematic way of learning from these complaints to prevent recurrence.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection, the service did not have a registered manager in post.

The registered manager's post had been vacant since October 2015. The provider had appointed a manager who had remained in the position for two weeks. After this, a registered manager from one of their other services was appointed as the interim manager at SOS - Statham House. CQC records confirmed that the interim manager was registered for one of the provider's other locations.

We discussed the issue of SOS - Statham House not having a registered manager with senior management including the nominated individual and the quality manager. We were told that the changes of registered manager had significantly affected the service's operations over the last four months but that the situation was under better control now. We were told that the interim manager was receiving support from the provider's operations director.

We were informed that the interim manager would be seeking to transfer their registration to this location. We subsequently looked at minutes of a senior management meeting held in February 2016 and found that the current interim manager would be leaving the service for an extended period of time. We asked the interim manager about this and they confirmed that this was the case. This meant that the service would continue to lack the stability and continuity provided by a permanent manager and demonstrated a lack of transparency and openness with the CQC.

We asked people and relatives if they thought the service was well led. Their statements were varied. They told us that they thought the service was well led although there were limitations. They said: "It is very, very good; I am very pleased", "I think it is well managed but I think they could do with more carers. They seem very busy", "Service appears to be managed well", "Not well led sometimes; I cannot understand why they take people on when they don't have the staff to deal with it. There are too many customers for the number of staff" and "On the whole they are alright; they are what they are". We asked people and relatives what, if anything, they would like to see improved about the service they currently received. The majority of people and relatives we spoke with said they would like to see more care workers and have better timing of visits.

Some people told us they knew who the manager was whereas others did not know. One relative informed us that "like care staff, there had been a number of different managers" so they could not comment on the culture and communication at the service or if it was well managed. One person told us, "Staff seem to enjoy what they are doing…I think they need to!" They added that the care staff spoke well of the service.

The nominated individual told us that they and other senior managers were always available to people using the service and to staff by telephone or visiting the office. Managers told us that the open planned office encouraged staff to know who the managers were and made them easily approachable. Care staff we spoke with thought that the managers were approachable and that the provider was good. They said, "They (the service) are good to me. They trained me to do the job and I'm enjoying the job" and "[Manager's name] is a good boss … has always been fair with me."

People and their relatives told us they were able to give feedback to the service about the support they received and had the opportunity to express their wishes. They told us they did this by either speaking with their care worker or by calling the office and that they felt listened to.

One person told us that they thought the service was open and transparent and said, "I can talk to them (the service) and they listen to what I am saying." A relative told us that they felt their views and opinions were taken into account and that staff have always responded positively. We were informed that the service sent out an annual quality survey to people using the service and produced a summary report of results. We saw that in 2015, 214 surveys had been sent out and that 23 people had responded. The summary report of the survey's responses highlighted positive comments people had made including these: "carers were polite", "carers provided tasks required" and "carers looked smart" and poor practice that people pointed out such as "They (care staff) all seem rushed", "They (care staff) go as soon as they're done" and "Carers not staying the required time for bed down calls". We saw an action point coming out of this survey that the registered manager and the quality manager were asked to resolve; it referred to care staff not staying the required time. We asked to see how this had been resolved but was told that the person had left the service and so no investigation had taken place. This meant that the provider and the service did not benefit from any lessons learnt which could improve quality in the future.

Some people and relatives we spoke with confirmed that they had received and completed a survey asking them to give their views about the support they received from SOS – Statham House. This meant that management were taking some action to find out the views of people using the service but given the poor response rate the service may have considered alternative ways to get people's meaningful feedback, such as anonymised responses. We saw no evidence of this.

We looked at the quality assurance systems that the provider had in place to monitor its services. These included quarterly quality management audits which were done by the quality manager, and operations reports prepared for the Operations Director by individual service managers. We asked to see the quality audits that had been done for the last quarter; we received reports for June 2015, December 2015 and February 2016. The quality management audit reports included audits of service users' care files, staff files, medication administration and calls or visits to people to ask them about the quality of the service they received. In two of the three reports we saw action plans with target dates. We did not see any evidence that these actions had been completed. We also did not see any analysis of the issues identified. This meant that the provider did not act to address the quality of the service, and outcomes for people had not been improved.

We obtained operations reports for July 2015 and August 2015, October 2015, and January 2016 to March 2016. These reports contained operational information including staff numbers, staff sickness levels, staff competency and spot checks, safeguarding referrals, missed visits, complaints and compliments. At the back of each report we saw a list of safeguarding issues and complaints with associated outcomes. However we did not see that this data had been collated and analysed to help the provider identify trends and learn from these issues.

We asked the interim manager, operational director and nominated individual about this and they told us they dealt with these issues on a day to day basis. This meant that the service reacted to issues that developed and provided little assurance that service specific incidents and overall quality of the service such as the timing of visits and staff performance would not occur again.

The service used an electronic care planning system which we were told helped to ensure that operational functions such as care plan reviews and staff spot checks were undertaken when they needed to be. We

checked if this was the case and found that care plan reviews of service packages had been done but that there were spot checks due. We noted that the quality audits raised this as an issue but were unable to see what actions had been done to address these exceptions.

Overall, this meant that the provider and interim manager were aware of the issues but had not taken adequate steps to address them. The lack of regular and systematic analysis of issues and no clear action planning when gaps had been identified through its audit processes meant that the provider was not effectively monitoring the quality of the service provided to ensure people received safe and effective care.

We found several examples of poor record keeping, omissions of information, documents that had been misfiled, and dates recorded and entries made that were not accurate. We highlighted these issues during our inspection. This meant that the service's records and data management systems needed to be strengthened to ensure that accurate information about people and staff were always readily available.

These issues were a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance, with reference to 17(2)(a)(b)(f).

The nominated individual told us, "We want to treat our staff well. We want to improve their value as a carer." They informed us of various measures that the provider introduced to improve staff morale and retention such as an employee benefits system, the use of a social media website, and recognising staff birthdays. They told us by introducing these initiatives they hoped to encourage inclusiveness and a sense of community given the isolated nature of the care worker's role. We were told and we saw from the provider's newsletter that the provider had begun to implement an employee recognition awards scheme in September 2015. However we found that this scheme had not yet been implemented at SOS – Statham House.

We asked about staff meetings and how often these were held. The interim manager told us that there had been no meetings of care staff for more than three months. This meant that staff did not have regular opportunities to meet with colleagues as a group and discuss service and other related issues. The interim manager told us that when they started at SOS – Statham House in November 2015 they had held two meetings with senior care workers. The purpose of these meetings was to get some feedback about how care staff, including the senior care workers, felt about the service. During our inspection, we were told that two meetings had been scheduled for March 2016. The first meeting was held while we were still inspecting the service and we were subsequently sent the minutes of this meeting. The reintroduction of team meetings would ensure that staff had ample opportunity to discuss service specific issues with each other and with the manager.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Some care plans did not contain people's personal histories and had insufficient details about individual outcomes and personalised description of care and support routines. Actions to reduce risks to people were not always specific to the person's needs. Care records gave directions to staff but with no detailed reference as to how their actions would mitigate the risk posed. Some care plans had inaccurate or missing information e.g. level of risk assigned to specific tasks. Regulation 9(1)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent forms were being signed by relatives of people who lacked capacity but the service had not done any mental capacity assessments or facilitated best interest decisions. The service had not kept records of 'lasting power of attorney' documentation in circumstances where people had delegated responsibility for health and welfare decisions to relatives. Regulation 11 (1)(2)(3)

Regulated activity	Regulation

Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service's safeguarding records had not been completed accurately. Actions taken in safeguarding matters had not been recorded for a three month period. The systems and processes in place to monitor safeguarding incidents were not effective. Regulation 13(3)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive regular supervisions and appraisals which was a part of their professional development. There were irregular spot checks of staff's performance on the job. Regulation 18(2)(a)

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 12 HSCA RA Regulations 2014 Safe care and treatment People experienced a high frequency of missed calls and late visits. There was insufficient care staff for the number of people receiving services. Regulation 12(1) Risks in people's care plans did not always provide enough and specific details to guide staff to manage their risks. In some cases, there was no evidence that particular risk assessments were being done or monitored, e.g. risk of swallowing or dehydration. Regulation 12 (2) (a)(b)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Data had not been collated and analysed to help identify trends and learning from incidents that had occurred. There was a lack of systematic analysis of audit findings and no clear action planning to address these gaps. There were examples of poor record keeping including missing and inaccurate information and misfiled documents.

The enforcement action we took:

Warning notice