Saffron Care Ltd

Saffron Care Agency

Inspection report

Upper Hermosa Road
Teignmouth
Devon
TQ14 9JW

Tel: 08000148689
Website: www.saffroncare.co.uk

Date of inspection visit:
12 September 2017
13 September 2017
21 September 2017
22 September 2017
25 September 2017

Date of publication:
21 December 2017

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

Saffron Care Agency is registered with the Care Quality Commission (CQC) to provide personal care to people in their own homes. At the time of the inspection the service was providing care and support to 260 people.

At our previous inspection in October 2015, the provider was meeting all of the regulations.

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

We received concerns from people who use the service, staff and the local authority. In response to those concerns we undertook this unannounced inspection which commenced on 12 September 2017 an ended on 25 September 2017.

Prior to us starting this inspection, the local authority placed the service into a multi-agency safeguarding process due to the concerns they had received. We also shared our concerns with the local authority commissioners and safeguarding team. These concerns related to missed and late visits, poor standards of care, medicines not being administered appropriately, allegations of financial abuse, and the registered manager's lack of response to complaints.

We found significant concerns which meant some people did not always receive their care as planned and were placed at risk of harm. Some people's packages of care are currently being reviewed by the local authority commissioners. In addition, the local authority quality monitoring team are working with the registered manager and staff to support them to bring about improvements. The registered manager made a voluntary agreement with us to stop taking new packages whilst the required improvements are made.

People had not received appropriate care and support. We found evidence that people had experienced missed visits. People were not always receiving their calls as planned. For example, one person told us "they usually come about 6.00pm to get my tea, the other evening it was about 9.50pm". Visits were not planned to allow for the gap between medicine doses or meals. Some people told us that staff did not stay for the length of time they were supposed to and they felt rushed. One person said "I should have 45 minutes. Some care staff rush me and at lunchtime some are only here 10 minutes." Staff told us they had to shorten visits as they had too many people on their rota and no travelling time in between. This showed the deployment of staff was not effective to ensure that people received their call as planned.

People did not always feel safe. People did not always know who would be visiting them or when they would receive a visit. Some people felt unsafe as staff did not know how to meet their needs. For example, one person said "My biggest worry is that some carers do not know how to handle my sling and hoist and I have

had to point out to them what they are doing wrong". Incidents that should have been reported as a safeguarding alert had not been sent to the local authority. People did not always receive their medicines as prescribed. The registered manager had not carried out required pre-employment checks to ensure staff were suitable to work with people.

We received mixed views from people and relatives we spoke with in regards to staff training. Some people and relatives felt staff were well trained, whilst others told us that care staff needed more training on delivering care. Some staff felt supported but others felt support needed to be improved. Team leaders had observed staff's care practice. However, our findings during the inspection showed the checks completed on staff's competency had not identified and resolved these issues.

People and relatives gave us mixed views regarding the staff working for the service. Some people told us staff were not caring towards them and they were not always treated with dignity and respect. Several people told us they had asked for staff members not to visit them but they had been again. People did not always receive care and support from staff who knew them. People told us they were unhappy with the lack of continuity of care staff. Where people had expressed a preference in relation to the gender of care staff who supported them, this was not always respected. Other people told us they were very happy with their care staff.

People did not always receive consistent, personalised care and support. Several staff we spoke with told us they would like more information about people so they could provide better support. For example, a staff member told us when people started to use the service, their needs were not always communicated to them before their first visit. One person spoke about the occasions when they had staff who were new to them. They said "I have to tell them what to do". People's care was not always reviewed and updated to ensure their care was still appropriate. This placed people at risk of receiving inappropriate care and support.

People's complaints had not been taken seriously, explored thoroughly and responded to in good time. We found numerous examples of people making complaints that had not been resolved by the registered manager. The registered manager told us they were aware that verbal complaints had not always been logged. During the inspection, they amended their complaints policy and introduced a concerns form.

There had been a lack of leadership, governance and managerial oversight of the service. The registered manager was not aware of many of the issues we identified. However, after our initial feedback, when we returned to the office they told us about the actions they had already taken and their plans to make the required improvements. This included employing a compliance manager and rota co-ordinator who were due to start in October 2017; putting a computerised monitoring system in place to make sure people received their visits; and giving team leaders protected time to carry out their role. The local authority quality monitoring officer had already visited the service to start working with the registered manager.

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

The overall rating for this service is 'Inadequate' and the service 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not having their needs met safely because they did not receive their visits as planned.

Staff recruitment practices were unsafe. The registered manager could not be assured people were being supported by staff who were suitable to provide care in people's homes.

Systems and processes in place to prevent abuse of people who used the service were not being operated effectively.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not always receive appropriate care as some staff had not received effective training and supervision.

People could not be assured they would receive support to have their food and drink at the times they needed them.

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

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always have continuity of care staff.

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

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

Is the service responsive?

Requires Improvement

The service was not always responsive

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

People were placed at risk of inappropriate care and support as care plans were not always reviewed and updated.

People could not be confident their complaints would be taken seriously, explored thoroughly and responded to in good time.

Is the service well-led?

Inadequate

The service was not well-led.

A lack of leadership, governance and managerial oversight led to the service being poorly managed.

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

People and staff were not always given the information they needed and there was a lack of communication.

Saffron Care Agency

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 between 12 September and 25 September 2017 and was unannounced. The inspection visits to the office were carried out by one inspector on 12 and 25 September 2017. One inspector carried out five visits to people in their homes on 13 September 2017. Two Experts by Experience made telephone calls to people who used the service and relatives on 21 and 22 September 2017. The inspector spoke to additional people and relatives on the telephone. During the inspection we spoke with 31 people who used the service and 13 relatives.

We reviewed concerns from people who use the service, staff, and the local authority. We looked at notifications we had received. Notifications are sent to the Care Quality Commission by the provider to advise us of any significant events related to the service, which they are required to tell us about by law. As part of the inspection process we also looked at the Provider Information Return (PIR). This 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. We received completed questionnaires from 19 people who use the service; four relatives; 23 staff, and one community professional.

During the inspection we spoke with 9 staff, the training manager, and the registered manager (who was also a director of the provider organisation). We looked at eight care plans including risk assessments, visit records, and records relating to medicines. We looked at four staff files. We checked how complaints were handled, and assessed and monitored the quality of the service.

Inadequate

Is the service safe?

Our findings

People did not always received their visits as agreed because there were not enough staff available at all times to deliver planned care. We found people had experienced missed visits and sometimes visits were very late. It was difficult to determine whether there were enough staff to cover the planned care visits as the visit records were not well organised. The registered manager did not keep a record of the hours care staff had worked each week. The registered manager told us they employed 110 care staff to provide 2600 hours of care and 4127 visits per week. We looked at staff's planned visits on their rotas. On a number of occasions, we saw staff were allocated to two visits at the same time, visits often overlapped, and there was no travelling time included in the rotas to allow staff time to travel to the next visit. The registered manager told us staff were allocated more than one visit at a time as they expected them to prioritise people's needs and provide the best outcomes for people.

Some people and staff commented there were not enough staff, to be able to attend their visits when required. People said "They don't have enough carers and it is pot luck who you get and when or whether they turn up"; "When our regulars are off we do eventually get someone to come" and "They don't always have enough carers hence missed calls". One person told us they had complained to the registered manager about the gender of the care staff who visited them as it did not respect their preference. They said "he tells me he is short staffed and doesn't have any female carers to send." A relative told us they had provided care for their husband, on one occasion, as their allocated staff member was off sick and the office had told them there was no one else available. One member of staff said the registered manager was constantly squeezing people in on their round which meant they had to shorten other peoples' visits. Another member of staff told us they had been told by the team leader to take some medication when they were unwell and carry on working, as they had no other staff to cover their visits. We found that the missed and late visits had an impact on some people's health and well-being, for example anxiety and distress and missed or late medicines. Some staff commented that team leaders often covered sickness which meant they were not able to contact them when they needed to. This could delay staff getting to their next visit.

We discussed this with the registered manager who told us the past couple of months had been difficult due to a number of staff being on annual leave at the same time. There had been some sickness absence in addition to this. This meant team leaders and the registered manager had to cover visits to people. The registered manager told us they had recognised this as an issue and was now monitoring annual leave.

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

People were at risk of not receiving appropriate care and support. The registered manager told us that missed visits would be identified by care staff checking the daily records, during a review, or if a person contacted them to inform them of any missed visits. There were no systems in place to check whether people unable to inform staff had received their visits. For example, we visited one person in their home. We found staff had not entered any information in their daily records for two visits on one day. The registered manager told us they were not sure if the visits were missed or not logged. After investigation, it was found

the two visits had been missed due to communication issues. The local authority also shared information with us about three other people who had a total of five recent missed visits. One person had become very anxious and distressed about the missed visits and this had an impact on their breathing difficulties. During our telephone conversations with people, we found a further 12 people had experienced missed visits.

We found systems did not protect people because they were not always receiving their calls as planned. For example, one person told us "they usually come about 6.00pm to get my tea, the other evening it was about 9.50pm" Another person said "I don't know who or when they are coming. It could be 8.00pm today and 3.40pm tomorrow. Not good if my morning carer doesn't get here until 11.00am to 12.00 noon".

Some people told us they felt rushed as staff did not stay for the length of time they were supposed to. One person said "I should have 45 minutes. Some rush me and at lunchtime some are only here 10 minutes." Relatives commented "If they think they've done their job they leave"; "Have left well within the time allotted" and "my mother pays for 30 minute visits but it often can be just 12 minutes". We looked at one person's allocated visits and actual recorded visits. Records showed staff did not stay the allocated time.

We looked at visit records in people's homes and found that staff did not always record the time they arrived and left. Therefore, it was impossible to monitor whether staff were staying for the full visit. Staff commented "calls overlap so not all tasks are always completed" and "we are still given four to five clients at the same time, with no travelling time in between. This makes it impossible to achieve a high level of care. Leaving clients distressed and medication times wrong".

People told us staff were often late. One person said "I am time critical, sometimes my care is very late. I do not always get personal care and I am in a constant state of anxiety and stress". Another person told us staff did not arrive to make their breakfast recently. Staff were so late this person told us they struggled to get their own breakfast and commented "I can't do what is needed it is no surprise I am losing weight". This showed the deployment of staff was not effective to ensure that people received their visit as planned.

People did not always feel safe and were not assured they would receive their planned visits at the time they needed them. The registered manager only sent out rotas to tell people which staff would be visiting them, if they requested this. This meant people did not always know who would be visiting them or when they would receive a visit. One relative said "If she doesn't know them, I think she feels scared". A person said "As I am blind it can be quite unnerving for someone new to suddenly appear at 7am when I can't see them and don't recognise their voice".

When the registered manager became aware of the extent of the issues relating to visits, during our inspection, they told us that they were installing a new system at the beginning of October 2017. This meant visits could be monitored more effectively.

People did not always receive their medicines as prescribed. Where visits had been missed, people had not received their medicines. We found gaps in medicine administration sheets (MAR) so it was not clear whether people had received their medicines. One person told us "They have left a tablet behind in the blister pack or dropped them on the floor" and "Sometimes they come really early in the evening so not able to give me my tablets, they put them in a dish and I have to remember to take them".

Where risks had been identified action had not been taken. For example, one person's care plan stated "(name) has regular paracetamol to take please ensure 4 hourly gap is given before administering". Records showed the medicine was not being given as prescribed because staff were not attending the calls at the required times. For example, on one day the medicine was administered during the teatime visit at 5.00pm

and the evening visit at 7.45pm. This medicine should be given with a gap of four hours between doses. This meant there was a risk of a potential overdose of medicines because they were not administered as prescribed. The appropriate levels of medicines would not be maintained in the blood stream to ensure pain relief was managed appropriately. Visits were not planned to allow for the gap between doses. Staff told us that they had completed medicines training.

Staff had identified that one person had a pressure ulcer and had contacted the district nurse. A team leader had reviewed this person's care plan on the same day but had not updated their risk assessment. This meant staff did not have information to follow to make sure the person's skin did not deteriorate further.

Some people felt unsafe as staff did not know how to meet their needs. For example, one person said "My biggest worry is that some carers do not know how to handle my sling and hoist and I have had to point out to them what they are doing wrong". A relative said "they don't look where the catheter bag is and it is kinked so it doesn't drain. I have to straighten it after they have gone".

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

The registered manager had not followed their safeguarding policy and procedure to ensure people were protected from the risk of harm. During our inspection we found evidence that allegations of financial abuse had been raised in June 2017. These allegations had not been raised with the local authority as a safeguarding alert. There was a further incident in August 2017 which was reported to the local authority. The registered person had not sent us formal notifications, as required by law. A notification was sent to us retrospectively during our inspection.

People were placed at risk of financial abuse as the registered manager had failed to ensure systems were in place to protect people were care staff had access to people monies. We spoke with one person who told us staff picked up some of their shopping for them. Staff drew monies out on a regular basis. However, the person told us staff didn't give them a receipt or explain what they had spent. They were not sure if the money they received back was correct.

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

Staff recruitment practices were not always safe. We looked at four staff files. We found that Disclosure Barring Service (DBS) checks had not been in place before staff went out to work in people's homes. The disclosure and barring service helps employers make safer recruitment decisions and helps to prevent unsuitable people from working with people who may be vulnerable. The registered manager has a legal responsibility to obtain these checks prior to staff undertaking care duties. The registered manager told us they had carried out DBS Adult First checks for staff but were unable to produce evidence of these. DBS Adult First is a service provided by the Disclosure and Barring Service that can be used in cases where, exceptionally, a person is permitted to start work with adults before a DBS Certificate has been obtained. Records did not show that the registered manager had explored two of the staff member's employment history to satisfy themselves about any gaps. Each staff file contained one reference. There was no evidence that the registered manager had sought further information about people's character or suitability to provide care to people. This showed that the registered manager had not monitored the recruitment process effectively.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

The service was in the process of putting a system in place to ensure visits to people who may be at risk were prioritised. This was being done as part of each person's review. This would be used in events such as severe weather conditions and staff shortages. The business continuity plan was being updated to include this information.

Requires Improvement

Is the service effective?

Our findings

We received mixed views from people and relatives we spoke with in regards to staff training. Some people and relatives felt staff were well trained, others told us that care staff needed more training on delivering care.

People did not always receive support from staff who were competent and skilled to meet their needs. One person who had complex care needs told us they had been visited by one new staff member and another staff member they hadn't seen for a long time, the weekend before we spoke with them. Comments included "I am worn out by constant new people and expected to explain my routine and teach them to cook" and "Not happy with new people with lack of training". People and their relatives told us staff did not always know how to meet their basic needs such as washing, shaving, cleaning teeth, brushing hair, and food preparation. They also had experienced issues with staff not knowing how to put on support stockings, use a hoist, or care for a catheter. The registered manager told us they had further training planned to address this.

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

Some staff felt supported but others felt support needed to be improved. Comments included "No support from managers, very low morale"; "Team leaders are covering care or driving non-driving carers around meaning more pressure is put on carers" and "I have been left with no other option, other than to look for another employment". However, other staff were happy working for the service. They told us "Saffron is a great care company to work for"; "I Love it and feel well supported" and "The manager is approachable and will do his best to help anybody".
There was a plan in place to ensure staff received regular supervision and we saw records of these. Supervision was regular, planned and recorded sessions between a staff member and their manager to discuss their work objectives and wellbeing. Other people told us they were happy with the staff who supported them. Comments included "They're very good"; "very competent; and "Most are excellent."

The registered manager had employed a new training manager in January 2017 and introduced a new training programme. They were holding three day induction training sessions at the local hospital. The induction met the requirements of the care certificate. This certificate is an identified set of standards that care workers use in their daily work to enable them to provide compassionate, safe and high quality care and support. Some people who used the service had agreed to new staff completing additional training in their homes with a team leader. In addition, new staff worked alongside experienced staff to observe how people had their care delivered. Once this had been successfully completed, staff competency was assessed through observation.

During our inspection we joined part of a training day. We observed the training manager involving new staff in discussions about how to keep people safe; confidentiality; and equality and diversity. The training manager used a range of methods such as slide presentations, case studies, hands on training using

equipment, and discussion. They had introduced a questionnaire that was used to check staff's knowledge at the beginning and monitor their learning and progress at the end of the training. The staff were keen to take part in the training and their feedback was very positive. They said "really enjoyed the hands on practical elements"; "I learnt a huge amount and feel well prepared for my role" and "excellent trainer."

The training manager had attended Dementia Friends training and was supporting staff to become Dementia Friends. They had also offered training to relatives of people living with dementia and some relatives had completed this. During our inspection the training manager attended falls training with the paramedics and a lifting cushion had been made available for staff to use. The registered manager told us they were developing a cook book for staff and training would be available.

Experienced staff said they had received a training update and told us "The training has definitely upped its game" and "the training procedure is amazing." Staff were encouraged to work towards diplomas in health and social care. One of the team leaders was taking part in the Skills for Care Aspiring Leader course. This course developed leadership potential and worked with other care professionals to share good practice.

Staff supported some people with their meals. We found many examples of people who experienced missed visits or visits that were not spaced appropriately. This resulted in them missing meals. During our home visits, we observed staff offering people a choice of their preferred foods. Drinks were left within people's reach. Staff told us how they left one person whilst they were eating as they knew this would result in them eating more. Another person told us how staff supported them to eat and talked them through it. Staff told us they would contact the office if people did not eat enough or they had any other concerns in relation to eating.

Some people who used the service were living with dementia. We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. At the time of our inspection, each person had capacity to make decisions relating to their care. People confirmed staff gained consent from them before carrying out personal care and respected their choices.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager confirmed no one was being deprived of their liberty. Therefore, no applications had needed to be made to the Court of Protection.

Most people who used the service were able to contact healthcare services independently. Staff told us if they had concerns about people's health they were able to contact healthcare professionals themselves. We saw evidence of occasions when staff supported people with their healthcare needs. For example, people told us about staff taking prescriptions to the GP and picking up medicines for them. One person had been waiting for a hospital appointment and hadn't heard anything. The team leader helped the person to follow it up. Another person told us "when I was poorly, they got the paramedics to come and sort me out." We received feedback from a healthcare professional who said "Easy to work with and generally responsive to requests and suggestions. They will feedback should problems arise" and "usually have up to date information on the clients I am dealing with".

Requires Improvement

Is the service caring?

Our findings

People and relatives gave us mixed views regarding the staff working for the service.

Some staff were not caring towards the people they supported. When asked about the staff that supported them, people said "Very rude. They make you feel second class people" and "She is nasty to me". A relative commented "I have had times where the carer has been rude and dismissive". One staff member said "not all carers are sensitive enough to user's needs".

People were not always treated with dignity and respect. One person told us one staff member didn't always reply when they asked them something. Another person told us staff didn't protect their dignity when washing them. They said "It is embarrassing when they are seeing to your intimate parts and don't put you at ease". Several people told us they had asked for staff members not to visit them but they had been again. People did not always receive care and support from staff who knew them. People told us they were unhappy with the lack of continuity of care staff. This had caused distress for people who were blind or were living with dementia who wanted familiar staff. Comments included "Too many faces in one week"; "I am worn out by constant new people" and "as soon as the regular carer has a day off everything comes to a grinding halt."

People's preferences were not always respected. Where people had expressed a preference in relation to the gender of care staff who supported them, this was not always respected. Comments included "I keep the chain on my door now so I can see which carer is coming"; and "If male carers come I tell them to go away". Another person said they wanted mature carers but they kept getting young carers.

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

Some people told us they had been involved in their care planning and were able to make decisions. Comments included "We were both involved in setting up the care plan and got what we wanted"; "I tell them how I want things done and they carry out what is needed"; and "My daughter was involved in setting up this care package, it is much better than the one I had with my previous agency. I get all the help I need and I am very happy."

Some people told us they were very happy with their care staff. Comments included "The carers I have are more like family"; "a lovely lady"; "I'm always hearing from (mum) how lovely and kind many of the care workers are" and "my carer is exceptionally good, I get plenty of company".
They said they could chat with their care staff. Comments included "We talk, laugh and joke and have some fun. They will make sure I have a drink and will sit and have a chat if time allows" and "I look forward to them coming as they talk to me about all sorts of things and we have a laugh".

We received feedback from a healthcare professional who said "Care staff are always polite and have good communication skills and rapport with their client".

During our home visits, we saw staff knew people well. They chatted with people about their interests and knew their preferences. One person was happy as she had chosen to stay in bed for a lie in and staff had respected this. Another person said "I'll have my favourite" when asked about lunch and staff knew which meal to prepare straight away.

Staff spoke about people with compassion. Staff said "I like to get to know people and I know the people on my run"; "my clients are very important to me" and "I know (name) likes to watch catch up television in the morning so I work around it, so he can".

People told us staff encouraged them to be as independent as possible. Comments included "As my condition improves they encourage me to do more for myself" and "They support me and encourage me to walk a little".

The service had received lots of compliments from people and their relatives thanking them for their care, kindness and compassion.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive consistent, personalised care and support. Several staff we spoke with told us they would like more information about people so they could provide better support. For example, a staff member told us when people started to use the service; their needs were not always communicated to them before their first visit. They said it's fine if people can tell you what they need but there was often little information in the house for them to follow. One person spoke about the occasions when they had staff who were new to them. They said "I have to tell them what to do". Another staff member said they were not always told about changes to people's needs. We saw the management had discussed this in the September meeting and were looking at ways of getting information out to staff.

People's care was not always reviewed and updated to ensure their care was still appropriate to their needs. One person told us they had asked for a review of their care plan due to their changed needs but had not seen the team leader for over a month since they had this conversation. A relative said "Not recently, it used to be every six months but not now. We have a new team leader but haven't met her yet."

The registered manager told us staff had been working with one person's family and social worker to put a plan in place to respond to specific needs. However, the updated care plan did not reflect what staff were actually doing. Another person had changed needs in relation to their skin care. Staff had recorded they contacted the district nurse and told us they were supporting the person to prevent further deterioration. A team leader had since carried out a review of this person's care needs in their home but had not identified the change in their needs or updated the care plan. This placed people at risk of receiving inconsistent care and support.

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

People and their relatives were aware of how to report a complaint or a concern, however were not confident this would be responded to appropriately. People told us they had contacted the office and raised complaints. We found complaints were not always logged, escalated to the registered manager or responded to. There were no records to show investigations had taken place, and how these issues were resolved.

People told us "You can complain all you like but it doesn't make any difference"; "I do shout when things go wrong, they might improve for 48 hours but it soon reverts"; "You are not encouraged to complain or raise issues" and "I might worry about retribution if I was to make a complaint".

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

The registered manager told us they were aware that verbal complaints had not always been logged. During the inspection, they amended their complaints policy and introduced a concerns form.

We looked at care plans that described the support people needed to manage their day to day needs. This included information such as their preferred routine, step by step guidance about how to meet people's needs and other information such as their food and drink preferences.

During our home visits, we found that staff knew people well and were able to tell us how they supported people. We saw staff followed each person's care plan. They responded to people's requests, met their needs appropriately, and knew how they liked things to be done.

The registered manager had introduced a new approach to providing support and allocating visits. They told us "We try and empower all carers to take a person centred approach to the care and support we provide. Moving away from the standard time allocation to a more outcome based approach". We spoke with several relatives who were part of this trial round. They were very happy with the care. Comments included "just brilliant"; "very consistent"; and "they know exactly how to look after (name)". One relative commented that they had not been told about a delay recently but other than that they couldn't praise them enough. A staff member who was part of this round said "It has been extremely effective and has enabled me to really centre the care to the client's needs. I know exactly what each client needs and wants and have been able to structure my working day around this."

Inadequate

Is the service well-led?

Our findings

People were placed at risk because there was a lack of leadership, governance and managerial oversight of the service.

Prior to us starting this inspection, the local authority placed the service into a multi-agency safeguarding process due to the concerns they had received. We also shared our concerns with the local authority commissioners and safeguarding team. These concerns related to missed and late visits, poor standards of care, medicines not being administered appropriately, allegations of financial abuse, and the registered manager's lack of response to complaints. Some people's packages of care are currently being reviewed by the local authority commissioners. In addition, the local authority quality monitoring team are working with the registered manager and staff to support them to bring about improvements. The registered manager made a voluntary agreement with us to stop taking new packages whilst the required improvements are made.

Since the last inspection in 2015, the service had grown in size. At this inspection, we found the number of people who used the service had increased from 180 to 260 people. The registered manager was responsible for the day to day running of the service. They were supported by a lead team leader, six team leaders, a co-ordinator, a recruitment lead, and a training manager.

Some people and their relatives told us the service was not well managed. They said they were not always able to speak with the registered manager or team leaders. Comments included "The same problems keep being repeated"; "we would like to think their management was a little more efficient and organised to give us the service we pay for"; and "I have been with this company a long time and it is now too big for them to manage". Other people were happy with the service and said it was organised and well-led.

People and staff were not always given the information they needed and there was a lack of communication. A new telephone system had been introduced where people needed to press options to reach the right person. People commented "It used to be easy to get through to the office but not anymore"; "this is a nasty system, you're told to press 1, 2, 3, or 4 and then asked to leave a message but no one gets back to you"; and "I refuse to leave a message because they won't get back to you. I keep trying until I get to speak to someone".

Staff commented "Management team could be improved – take time to listen to us, support us and not ignore our calls"; and "communication at times isn't very good. We have to be mind readers."

People and their relatives told us they didn't feel lessons were being learned or issues acted upon appropriately. They said "You can complain until you are blue in the face but nothing changes" and "The service has not improved in spite of my complaints".

The systems and processes in place did not ensure people's individual care needs were met, risks were minimised or care was delivered to keep people safe. We found visits were not monitored to ensure people

received their visits. Minutes of a staff meeting in May 2017 highlighted issues relating to staff needing to write visit times in daily records and checking of rotas to make sure people had not been added. These were still identified as issues at this inspection.
The provider information return stated that 800 quality assurance visits had been carried out in the past 12 months to monitor staff's care practice. Our findings during the inspection showed the audit checks completed on staff's competency had not identified and resolved issues.

We looked at audits that had been carried out by team leaders and found issues we identified had not been picked up. For example, one person's review and audit had been completed two days before our visit and confirmed everything was completed. However, we found issues relating to visit times not being recorded; changes to care had not been updated; and medicines had not been recorded correctly.

Records were not always complete. We asked to see the log of missed visits and found the recent missed visits had not been recorded. During the inspection we became aware of complaints that had been raised with the registered manager but not recorded. Staff files did not contain all of the information required by law. Daily records in some people's homes were not written clearly so other people could read them.

Saffron Care Agency sent out a survey to people who used the service in January 2017. The registered manager told us 112 people had responded. Feedback had not been sent out to people and the registered manager told us they would do this for the next survey. An action plan had been written and we saw some actions had been taken. For example, recruiting more team leaders, and changing the training programme. However, issues such as better communication, continuity, and responsiveness had still not been resolved.

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

The registered manager had failed to make an appropriate safeguarding referral following an incident. They confirmed they had not notified us, as legally required. The notification was sent to us once they became aware they needed to do this. This demonstrates that the registered person did not have systems in place to ensure important information was communicated.

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

The registered manager was not aware of many of the issues we identified at the beginning of the inspection. However, after our initial feedback, when we returned to the office they told us about the actions they had already taken and their plans to make the required improvements. This included employing a compliance manager and rota co-ordinator who were due to start in October 2017; putting a computerised monitoring system in place to make sure people received their visits; and giving team leaders protected time to carry out their role. The local authority quality monitoring officer had already visited the service to start working with the registered manager. The registered manager told us they were determined to put things right for people and staff and said "We are implementing new systems and processes to support both carers and clients. These systems will allow us to provide a better service in the future and also enable us to identify and resolve issues quicker leading to an improved customer experience."

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 18 Registration Regulations 2009 Notifications of other incidents Regulation 18 (2)(e) Allegations of abuse had not been notified without delay.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 (2) Recruitment procedures were not operated effectively to ensure staff were suitable.

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 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 (1) Care and treatment was not appropriate and did not meet people's needs or reflect their preferences.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 (1) People were not treated with dignity and respect.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1)(2)(a)(b)(c)(g) Care and treatment was not provided in a safe way.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (1)(2)(3)

	Systems did not protect people from the risk of abuse.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Regulation 16 (1)(2) Complaints were not investigated and action was not taken.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (2)(a)(b)(c)(d)(e)(f) Systems were not effective and were unable to monitor quality or minimise risk.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) Sufficient qualified staff were not deployed to meet care needs.

The enforcement action we took:

Impose a condition