Annies Homecare Services Ltd

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Inspection report

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Tel: 01621773672

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

On 14 September 2016 we inspected Annies Homecare Services Ltd and found them to be in breach of one regulation under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breach of Regulation 17 was in relation to the lack of management systems for the monitoring of the health, safety and welfare of people. We rated the service as 'Requires improvement' for Well Led and 'Good' in the four other key questions with an overall rating of 'Good'. We asked the provider to complete an action plan to show what they would do and by when to improve the key question Well Led to at least 'Good'.

We undertook an announced focused inspection of Annies Homecare Services on 10 November. This inspection was done to check that improvements to meet the legal requirements after our September 2016 inspection had been made. We saw that whilst some actions had been taken, there had been minimal improvements made. We therefore returned on 16 November 2017 to undertake a comprehensive inspection. We found that the service was still in breach of Regulation 17 as the required improvements had not been made. In addition, we identified breaches of Regulation 9 (Person centred care), Regulation 10 (Dignity and respect), Regulation 11 (Consent), Regulation 12 (Safe care and treatment), Regulation 18, (staffing) and Regulation 19 (Fit and proper persons). You can see what action we told the provider to take at the back of the full version of the report.

Annie's Homecare service is a domiciliary care agency. It provides personal care to people living in their own homes in the community. It provides a service to older and younger adults. On the day of our inspection, 52 people were using the service.

A registered manager was in place. 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.

People were at risk because the provider did not have robust processes in place for keeping people safe. Risks to people's safety were not assessed or sufficiently detailed to understand their needs and to minimise risks to their health and wellbeing.

Staff were not recruited safely with the necessary checks in place and in line with the legal requirements to ensure they were safe to work with people in the community.

Medicines were not being administered or managed correctly and people were at risk of not having their medicines as prescribed and at the correct time. Investigations and lessons learnt were not always undertaken when incidents and accidents occurred. Infection control procedures were not sufficient to support staff in carrying out their role safely.

People's needs were not holistically assessed to achieve effective outcomes for them. A system for the

training and supervision of staff was in place but this was not sufficiently robust to ensure staff had the necessary information, skills and knowledge to carry out their role effectively. Staff had not received sufficient training to support people at the end of their life.

People's capacity to make day to day decisions was not assessed or recorded and their consent about their care and support arrangements was not obtained to ensure their wishes were carried out.

People were not always treated with dignity and respect or their privacy maintained. The involvement of people and their families in the planning and decisions about their care were minimal as care plans were not person centred and did not identify people's communication needs, wishes or views.

The management of the service was not well led. The leadership did not promote an open and positive culture. There was not a robust system in place to monitor measure and review the quality and delivery of the service or involve and engage with staff in its development.

We have made a recommendation that the provider make themselves aware of and implement the requirements of the Accessible Information Standard.

Staff had knowledge of the safeguarding procedures and were clear about the actions they would take if they saw, heard or suspected any abuse or harm to people they supported.

There were sufficient staff to care for people safely as the registered manager and other managers provided hands on care as required. The scheduling of the rotas meant that people had consistent and familiar staff.

People's health needs were met as staff liaised well with health and social care professional. People were supported to be able to have their meals as and when they wanted them which met their nutritional needs.

Staff understood people's day to day needs and caring relationships had developed as staff engaged with people in a kind and compassionate way. People were satisfied with the staff who provided their care and support.

People knew how to make a complaint and who to at the service and complaints were recorded and dealt with appropriately. A process was in place to seek people's views about the service either through reviews or annual surveys.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Risks to people's health and wellbeing were not assessed and recorded.

Staff had not been recruited safely and in line with legal requirements.

The procedure for the management of medicines and infection control was not sufficiently robust.

Staff were aware of safeguarding procedures and keeping people safe.

Is the service effective?

Requires Improvement

The service was not effective.

Staff had not received the training and supervision they needed to provide them with the necessary knowledge and skills to carry out their responsibilities.

People had not consented to their care arrangements and their capacity to make decisions about their care was not assessed or recorded.

End of life care was provided but staff had not had the necessary training.

People's health, social and nutritional needs were met by staff who understood how they preferred to receive their care and support.

People were supported to access healthcare professionals when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not respect people's dignity and privacy when providing personal care.

People were not always involved in their care arrangements.

Staff were attentive to people's needs and helped them maintain their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were not holistically assessed or written in a person centred way.

Staff were flexible and responsive to people's needs.

There were processes in place to deal with people's concerns or complaints.

Is the service well-led?

Inadequate

The service was not well led.

The leadership and management of the service were not effective.

There was not a robust system in place to monitor measure and review the quality and delivery of care.

People who used the service and the staff were not involved in the development of the service.

Staff demonstrated a commitment to working for the organisation and meetings people's needs.

Annies Homecare Services Ltd

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 had made improvements to the service and was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to look at the overall quality of the service under the Care Act 2014.

We undertook an announced inspection of Annies Homecare Services. The provider was given notice of our visit because the location provided a domiciliary care service and we needed to be sure that someone would be in the office. The service was inspected by one inspector.

The Inspection site visit activity started on 10 November 2017 and we returned again on 16 November 2017 and completed the inspection on 22 November 2017. On the days of the inspection we spoke with the registered manager, the manager and deputy manager at their office location. We also spoke with six care staff and visited three people in their homes. We reviewed seven care records, three staff recruitment and training files and looked at records relating to the management and quality of the service.

Before the inspection we reviewed the action plan provided by the registered manager after the previous inspection, information we held about the service including any safeguarding concerns and statutory notifications. Statutory notifications include information about important events which the provider is required to send us by law. We asked the provider to send us information in relation to policy and procedures and training after the visit, which we received.

Requires Improvement

Is the service safe?

Our findings

Risks to people's health and safety were not always being fully assessed. Also, where some risk assessments had been undertaken, the recording of how to manage those risks was not always transferred to the care records for staff to refer to. For example, information in a referral from social services stated that the person was at risk of poor personal hygiene, skin breakdown; malnutrition and dehydration. However, this information had not been transferred from the referral to the care plan. The manager had not assessed the person's needs and put in place a system to manage those risks identified in the referral.

A recent review of a person's care in October 2017 when they returned after a month in hospital recorded 'no change to care plan'. However, we were told by the manager that, "They are really not eating and drinking as they have given up and staff have been ringing us every day to tell us." Whilst staff were verbally told what actions to take, the care plan had not been updated or monitoring of the situation recorded to minimise and prevent the risk of malnutrition and dehydration.

We noted the lack of assessing risk and the conflicting information contained in a care plan for another person. Their medical history had been recorded as 'memory issues' and their physical disability as 'falls.' On the safer handling plan, it was recorded that they were 'independent' and the risk action plan recorded 'no risks identified.' However, in the referral information from social services, it had been recorded that a best interest decision had been made by professionals as the person did not have capacity to look after themselves and may refuse support. No risk assessment had been completed regarding them not taking their medicines, not eating and drinking and not having their personal care needs met. No risks had been recorded about the restrictions on their freedom, choice and control. This placed the person at risk of not receiving the care and support they needed.

Accidents and incidents were not fully recorded. For example, we saw on a risk action plan that a person had 'fallen out of bed a couple of times.' No investigation had taken place as to why this had happened, if the person's needs were changing and the only action recorded was to 'make sure the bed is as low as possible and a quilt put on the floor next to the bed.' We were not aware if staff knew the correct procedures to care for this person safely. We did not see the involvement of people or their representatives in looking at the risks or the solutions to their health and safety.

Some staff understood their role and responsibilities in relation to infection control and told us they had adequate supplies of PPE (personal protection equipment). Records also showed that a spot check on some staff had been undertaken to observe this area of staff's practice. However, we saw in the training records that not all staff had received training in infection control. We also observed an unhygienic practice take place when a staff member did not change their apron when moving from a person's bedroom to the kitchen after giving them personal care. When we looked at the services' policy guidance to know what the procedure was, it was unclear as to the action the staff member should take. The current policy and procedure did not contain current guidance or sufficient information in order to keep people safe from the risk of infection.

The registered manager had no records to show that they had dealt with any investigations or safety incidents which had had an effect on people using the service. There had been no lessons learnt and changes to practice identified in either the management audits or communication in people's care records. We saw concerns which were not reported in a timely way and therefore people could be at risk if the necessary action was not taken to protect them.

People were not being given their medicines in a safe way. At the last inspection on 14 September 2016 we found the Medication Administration Records (MAR) were not completed robustly. People's names were still not being recorded on the MAR charts when they were returned to the office for audit. The manager had audited some of the MAR charts when they were bought to the office on a monthly basis, and recorded the reasons for the gaps, for example, if the person had gone out or when a relative had administered their medicines and not the staff.

However, we saw gaps which had no explanation or reason as to why a signature was missing. The manager was unable to explain why the signatures were missing. We saw that a staff member had recorded in the daily notes for one person in July 2017 that they had 'Found yellow pill on floor by chair'. The manager told us they were not aware of this so no investigation had taken place as to the effects this may have had on the person, if and why they had missed their medicine and why the staff member had not reported it to the manager. They had not followed their own policy and procedure.

Staff did not always follow the provider's medicine policy with regards to the handling of medicines, as we saw the senior care staff take out the tablets by hand from a person's blister pack and put them on a dish for them to take. They had not followed their own policy and procedure about how tablets should be removed from their packaging.

Some records included information for staff about the correct medicine dosage and time to be taken. However, some did not include this information. It was not clear how the staff could support the person to have the medicine as it had been prescribed. In one example special instructions had not been recorded on the MAR chart where a medicine was required to be taken at a particular time because it needed to be taken 30 minutes before food. Again, it could not be demonstrated that this was happening.

Some MAR charts were illegible, difficult to read and very messy. We spoke to the registered manager about some of the writing and recording we saw and they agreed.

A staff member did not know of a medicine they were assisting a person to take or what it was for. They said they were not given details about any of the medicines people took but it would be very useful to have in the care plan so they could refer to it and understand its use. They gave an example of when they were supporting a person who couldn't see and they refused to take the medicine because the staff were not able to tell them what they were taking it for.

The medicines policy was not up to date with current good practice guidelines relevant to providing medicines to people in the community.

This is a breach of Regulation 12 (1)(2)(a)(b)(g)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected by the service's recruitment procedures as checks were not undertaken in line with legal requirements to ensure that staff were safe to work with people using the service.

Recruitment records for two staff members employed in 2016 showed that a Disclosure and Barring Service (DBS) check had been applied for by the service and sent to the person it concerned. An email was sent to the service telling them that these were satisfactory.

Where one staff member's DBS identified a conviction, the provider had failed to explore this or put a risk assessment in place to show what measures had been taken to ensure the person was suitable to work with people in the community. We raised this with the manager and registered manager and they confirmed that this had not been undertaken. They also confirmed that the person was not currently working with people at the service so we were assured that people were not currently at risk of harm. The provider told us this would be addressed with the person before they returned to work.

The registered manager had not verified one staff member's references and assured themselves that they were satisfactory or obtained details of the reasons for the gaps in their employment which had not been accounted for. Another person's file did not contain a photograph or identification to confirm who they were. This placed people at risk if staff were not found to be of good character before they were employed in the service.

This is a breach of Regulation 19 (1)(a)(2)(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People felt safe with the care and support from the staff who visited them in their home. People said, "I do feel very safe with them, they look after me very well," and, "I would feel safe with any of them who come to me." However, despite the views and experiences of people we found that systems were not in place to keep people safe.

Staff understood their roles and responsibilities regarding safeguarding people and protecting them from harm. They were able to demonstrate how to report concerns should they see or hear anything which concerned them. Staff shared information and any concerns they had with the senior staff member or the manager. The staff were confident that action would be taken if and when they reported any actual or suspected harm to anyone. The manager had made safeguarding alerts to the relevant authorities and we saw that they had undertaken internal investigations with outcomes and actions.

Staff knew how to record and report incidents and concerns. They knew how to make contact with relevant professionals such as GP's and 111 for advice if they had concerns about a person's safety as we saw this in people's daily notes.

Safety checks were undertaken and recorded for hoists and slings in people's homes to make sure they were safe before being used. Environmental assessments had been completed and any internal and external risks noted so that people and staff could access the property safely.

The number of missed and late calls were very low as the staff had sufficient time to get from one person to another and to spend the right amount of time with them. Any calls to the office from people saying that their staff member was late were recorded in the complaints folder and the action taken.

Staffing levels were worked out in relation to people's needs. The registered manager and manager told us that they had sufficient staff to meet people's needs but this did mean that they were also called out when there were staff absences. The manager worked on the rota weekly in order to monitor the care provided to people and be a second staff member where two staff were required to provide care. The registered manager and the deputy manager also provided care when required when staff took annual leave or were

off sick.

Rotas were organised in advance and staff knew who they would be seeing and at what times. One staff member told us that sometimes they only knew the day before what calls they would be doing and additional calls were added on without prior notice. The duty system for on-call was shared between a senior staff member and the manager and we were told by staff that they were responsive to their calls if they needed them and the system worked well. People who used the service generally knew who would be visiting them on a regular basis.

Requires Improvement

Is the service effective?

Our findings

Staff were not working within current legislative guidelines and good practice as the provider's policy and procedures were not comprehensive or up to date. For example the medicine management and infection control policy did not contain essential relevant information for staff to refer to in order to ensure people are not exposed to the potential risk of harm.

The system for the training and induction of staff was not effective as staff and management were not sufficiently skilled and knowledgeable to provide high quality care.

We saw from the training programme for 2016 and 2017 that a range of training was provided which included moving and positioning, safeguarding people from harm and medicine awareness. However, not all staff had received training in food hygiene, infection control, catheter care, pressure care and dignity and respect and that only one staff member had completed first aid training in 2016. Our observations showed that even when training had been undertaken checks on staff's on-going competency were not undertaken regularly enough to ensure that poor practice was identified and skills developed.

Staff had one spot check on medicine administration in 2017, but during our inspection we identified examples of poor practice which showed staff were not always following best practice procedures, guidance or training. For example, the handling of a person's medicines. Their policy stated, 'if removing a tablet or capsule from a blister pack, this is best achieved if tipped or pushed out over a small plate from which the service user may then pick up and self-administer.'

The deputy manager had undergone a 'train the trainer' course in moving and handling in order to provide 'in house' training to the staff. They told us they had been provided with a handbook on all of the training required and updated it with information from relevant sources such as NHS Choices and Skills for Care websites. They told us they had sought advice about implementing the Care Certificate (the new vocational qualification in social care) and had decided against it and to continue to follow their own handbook. The deputy manager did however say during the inspection that they would look into implementing this.

The provider was unable to show us how the senior leadership team (including themselves) kept themselves up to date and ensured that their practice set the right standard.

All staff had received at least one supervision session from a manager about their role in 2017 and these were often combined with a competence check at a person's home. The notes of the session regarding their practice and competence to perform their role were brief and did not always identify their learning needs or areas for development. For example, the registered manager told us that a staff member whose writing was illegible had been told that it was not good enough on a number of occasions. When we looked at their supervision for September 2017 there was no mention of how poor their writing was, how this impacted on the quality of care provided or any suggestions or support to improve.

The provider did not have a system in place to ensure that all staff were fully trained and supervised in order

to undertake their role effectively.

This is a breach of Regulation 18 (2)(a) of the HSCA 2008 (Regulated Activities) Regulations 2014.

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

We identified at the last inspection, that staff had not received any training and guidance in the Mental Capacity Act (MCA) 2005. The provider confirmed in their action plan that training had been put in place and completed for all staff in November 2016. Staff were aware of the MCA and the majority knew how it applied to people living in their own homes.

However, staff practice varied. Staff told us how they would seek people's consent before undertaking any tasks and we saw some of this in practice. However, we also saw that consent was not gained before a staff member undertook intimate personal care for a person.

People's capacity to make decisions for themselves was not always assessed or recorded. Where people's medical history suggested that they might have difficulty in making some decisions, this had not been explored or assessed. In one case an MCA assessment about significant decisions had been completed by professionals and the care package was in place against the persons' wishes but in their best interests. There was no information in the person's care plan to ensure staff were aware and understood the potential impact of this person's needs and their capacity.

We saw that the majority of people or their representatives had not signed consent to their care and support arrangements. We were unclear from the records as to how much involvement people had received in the assessment of their needs and in agreeing that these assessments were correct.

This is a breach of Regulation 11 (1) of the HSCA 2008 (Regulated Activities) Regulations 2014.

Despite these shortfalls, people told us that they were happy with their care arrangements and the tasks that were undertaken for them by the care staff. One person told us, "They ask me what I want to do each time they come", and, "They have been coming long enough they know what to do." One family member said, "They always have a chat with [relative] before they get on with things."

People were supported to have sufficient amounts to eat and drink and to maintain a balanced diet. We saw evidence in the daily notes of the food and drink people had and, if their food was monitored, the amount was also recorded. Staff offered people choice of what to have to eat and left drinks for them during the day to encourage them to have plenty of fluids.

Staff and organisations worked together to deliver effective care such as emergency hospital admissions, discharge arrangements, liaison with the pharmacy and GP on the person's behalf.

People were supported to access healthcare when required. Referrals were made quickly when people's health needs changed. We were told by the registered manager and manager about people's health and wellbeing and how they liaised on people's behalf with professionals such as their GP, occupational therapist and district nurses where there was a need identified. We did not see in people's care files any

information relating to the communication and liaison with professionals. The manager told us that these were all saved on the computer and subsequently they sent us copies of referrals and correspondence to show that liaison on a person's behalf was taking place. We discussed with the manager the importance of key information relating to the person's health and wellbeing being available in the care plan. They agreed to record contact with professionals and the action taken so that this can be followed up if needed.

Requires Improvement

Is the service caring?

Our findings

The service did not always ensure that people were treated with kindness, respect and compassion.

We saw information in the care plans which was not written in a person centred way or respectful of the person's needs, circumstances or care arrangements. One person's care plan read, 'Assist personal care, cream/ dry/dress, and prepare breakfast, meds to be given, blister pack in cupboard.' Whilst a front sheet in the care plan told us a bit more about the person, such as who they lived with and in what type of property, the person's wishes, preferences, choices had not been recorded. This did not show us that the staff who wrote the care plans were respectful and caring.

People's privacy and dignity was not always respected. One act of disrespect we observed was in relation to a medicine error. Staff were not concerned that a person they were attending to may not have received their medicine the day before as there was a gap in the recording of the MAR chart. They did not contact the office to ask about the effects on the person of not taking the medicine. Another act of disrespect we saw was where a person was denied their right to privacy. The staff member lifted up a person's skirt to check their incontinence pad without asking them if they could do so and whilst they were talking with a visitor.

This is a breach of Regulation 10 (1)(a) of the HSCA 2008 (Regulated Activities) Regulations 2014.

During our inspection we observed, heard and read how staff communicated with and about people. Most staff were kind, caring and compassionate. People told us, "[Name of staff member] is great, really kind and they know their stuff," and, "Lovely, they are all lovely to me."

The service supported people to express their views and to be as independent as possible. People told us they felt listened to by the staff. Many of the staff had been working with the people they supported for many years. They had got to know each other and had built up positive relationships. One relative said, "I don't know what we would do without them." Another person told us, "Without them I could not have come home from hospital, they have made it all possible."

The rota arrangements gave staff enough time to spend with people and were not rushed. This enabled time spent with people to be valuable and tasks could still be to be undertaken in a timely way and in the person's own time.

Staff helped to build and maintain people's independence and confidence. In our discussions with staff, we got an understanding about the people they supported and their history and how they enabled them to live at home. People told us, "They have helped me put on weight as I lost quite a bit but now am eating better thanks to them." People told us they had been grateful for the care provided and one person said, "I wouldn't change it for anything." One staff member told us, "People we go to are so lovely, if they had their way we would be there all day chatting away."

The written content, style and tone of the daily notes were mostly written in a factual but sensitive way. Most

of them were legible and the content showed a respectful familiarity and good rapport with people who were valued by the staff. People's records were kept confidential in locked filing cabinets at the office and in their own home.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive personalised care that met their needs. We did not see evidence that people were fully involved in their care plan arrangements. We saw that minimal information about their wishes, preferences and preferred times of visits had been discussed and agreed or if they required a particular gender of staff member to provide their care.

The care plans were not written in a holistic and person centred way. They were task focussed and contained basic details about the care to be provided. For example, one person's file read, 'Personal care on the bed, catheter care, pad change, dressing, transfer using hoist, meds, food, fluids/tidy up.'

We also saw that there was inconsistency in the way the assessment of need and reviews were carried out and the quality of the information recorded and completed. Whilst some care plans contained more details than others, such as the use of a hoist, monitoring a person's eating and bowel movements, falls and pressure areas, some risk assessments were incomplete. For example, it had been recorded that the person's medical history included memory issues and falls. However, there was no detail about how this impacted on the person and how their support should be delivered. The minimal information contained in the care plans was not sufficient to have an understanding of the person, their needs, views and their quality of life.

Reviews of people's care were carried out by the registered manager and manager and these were mostly completed by telephone. We saw that minimal information was recorded about each review, for example, 'Telephone call with [person's daughter], no problems with staff,' and, 'Happy with care, no change to care plan.'

Important changes to people's health were not updated in the care plan in order for staff to know how to respond appropriately where their needs had changed. One staff told us that requests in the daily notes were not always followed, for example, staff taking the time to hoist people to the toilet instead of them being left in an incontinence pad. They had told the manager about this and the manager asked staff to remember to text the next staff member going there to remind them to undertake the task correctly. We checked the care plan and whilst it told staff that the person used a hoist and how to attach the hoist, there were no details about the agreed arrangements, timings and how their care was to be delivered.

End of life care was not currently being provided for anyone using the service. The deputy manager was completing an assessment for someone who needed palliative care during the inspection. The training programme did not however provide evidence that the management or the majority of the current staff had received training in end of life care or bereavement. We would not be assured that staff had the correct knowledge and skills to respond to people and their families appropriately.

This is a breach of Regulation 9 (1)(2)(a)(b)(c) of the HSCA 2008 (Regulated Activities) Regulations 2014.

From 31 July 2016, all organisations that provide NHS care or adult social care are legally required to follow

the Accessible Information Standard. There was not sufficient evidence to show that a person's sensory and communication needs were assessed. For example we did not see in any of the care files any reference to their eyesight or hearing or the equipment they might need. There was no information regarding their preferred ways of communicating and receiving information. The registered manager and manager were not aware of the Accessible Information Standard which requires providers to ask, record, flag, share and meet people's communication needs as identified.

We recommend that the provider make themselves aware of and implement the requirements of the Standard.

Staff told us that they knew people very well and were able to respond to their needs. We observed this in practice and staff were receptive and responsive to the requests people made.

People's daily notes were available in their home where staff recorded information which allowed them to be kept up to date of the care and support people had received and for any instructions or changes needed. We saw previously completed copies which gave an understanding of the care which had been provided.

People told us that they knew who to contact if they had any concerns or complaints. They had received information relating to this. Some people told us they would inform the registered manager or the manager as they knew who they were. We saw that verbal as well as written complaints had been recorded and responded to. There were no outstanding complaints in progress.

People told us that their needs were met in a timely way and they had consistent staff who responded to them individually, met their needs and had very rarely been let down. They saw regular staff that were consistent and knew them well. One person said, "They are always there for me," and, "They are always reassuring when I ring the office and say they are on their way and check I am okay."

Inadequate

Is the service well-led?

Our findings

At the inspection on 14 September 2016, we found that the service had failed to have systems or processes in place to assess, monitor and improve the quality of the service as well as involve staff in its development. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager told us in their action plan that they would audit the records and implement new paperwork such as risk assessments and medicine sheets. In addition, they told us all staff had received training in the Mental Capacity Act (MCA) 2005.

We inspected Annies Homecare Services Ltd on 10 and 16 November 2017 we found that they continued to be in breach of Regulation 17 of the Health and Social Care Act 2008, (Regulated Activities) Regulations 2014. There had been minimal improvements made and the quality assurance system in place to monitor the quality of the service for people who used it and the staff was still insufficient and not well managed.

The provider did not have a clear vision to deliver high quality care. The registered manager was also the provider. The registered manager worked together with a manager and a newly promoted deputy manager who was also the 'in-house' trainer. During the inspection, we observed that the vision and values of the provider to deliver high quality care and promote a positive culture that was person centred, open, inclusive and empowering was not in evidence. The registered manager and the manager had not updated their skills and knowledge in order to lead and manage the service effectively.

The management and staff did not always talk about each other with caring and respect. Staff told us that some staff were displaying behaviour which was uncaring and disrespectful to each other. One staff member told us, "Some of the girls are falling out and arguing I really don't want to get involved." Another staff member said, "I don't think that the staff arguing has any effect on the people they visit, but it's bound to in the end if staff are that unhappy."

Staff told us that the managers did not manage the on-going conflict and negative staff behaviour that was happening in the service and this was having an effect on their work, their motivation and overall well-being. One staff member said, "I really don't like it, it's not what I come to work for." The manager's themselves described to us how difficult it was to manage the staff and their behaviour and were unable to come up with any management plans for tackling this except for, "Having a staff meeting about it."

The provider's governance framework did not ensure that responsibilities were clear. Quality performance, risks and regulatory requirements were not understood and managed. The role and responsibilities of the management team were not organised in such a way that it was obvious who managed what part of the service.

When we spoke with all of the managers, they were not aware or up to date about the regulatory requirements of providing a regulated service to people in their own homes. The registered manager said, "We all mix in and help each other out, [name] does all the training but we all do a bit of everything and that's how we work." We also spoke with the senior care staff who told us that they also had a management

role as they supervised the staff, did spot checks and provided on call advice and additional support when two staff were needed. However, when we asked to see the supervision records, no supervisions had been undertaken but the registered manager was unaware of this. This was another example of the lack of clarity of roles and consistency in the management and quality of the service.

Staff were not always engaged and supported to question practice and there was not a system in place to encourage staff to discuss their views and opinions. At the last inspection, staff told us that they did not have the opportunity to share their views and ideas about their work or the service and that staff meetings were minimal. There had been very little improvements made in this area since the last inspection. There had been two staff meetings in a year and the last meeting in September 2017 was arranged to address recent confidentiality issues and the poor conduct and behaviour of staff. There were actions recorded from this meeting, however, those staff who did not attend the meeting, were not given a copy of them. They also were not dated and signed by the manager or staff to say that they agreed with them and would put the actions into practice.

When we asked staff about being involved, most had no expectation or little interest in how the service was run and developed. However, they told us that, "More staff meetings to bring everyone together, if we are paid to attend, and that managers deal with poor staff practice". This would help them to feel more supported. One staff member said, "I really like my job, I am happy just doing my caring job." Another said, "Morale is really low at the moment, the managers have got to do something."

When we asked the registered manager what resources they had in place to develop the staff team and the service generally, they told us that they could, "Not afford to put in place any more improvements." We asked if staff were paid to attend training sessions or staff meetings and they said that they, "Could not afford to pay staff to attend so it was up to them if they attended or not, we can't force them."

No staff surveys had been undertaken. Surveys had been sent to people who used the service in November 2017 and two had been returned and they were happy with the service. We saw during our visit that a staff member sat with a person and wrote in the survey what they wanted to say. When we questioned if this action was appropriate, the staff said, "Its fine to do it, [name] tells us what to say and we write it." The views of people were obtained however, we were unclear as to how valuable their views were if they were completed in this way.

There was still no coordinated, organised and effective system in place for the monitoring of the quality of the service. The service had no on-going improvement plan or business continuity plan to oversee the service. We saw that minimal supervisions and competency checks had been completed, care plans had not been audited to ensure they were up to date, risk assessments and reviews of people's care were minimal if recorded at all and the audits and maintenance of the medicine administration records were disorganised.

Audits had not been carried out to ensure that staff were safely recruited. The registered manager had not undertaken the relevant and appropriate checks such as risk assessments for people with criminal records to ascertain that they were safe to work with people in the community.

We looked at the provider's policy and procedures. We viewed the policy for safeguarding adults who may be at risk, control of infection and infectious diseases policy, and the medicine policy and procedure. We asked the deputy manager if they had had any input into the writing of the policy and procedures as they were used as part of the training for staff and they replied that they had not. The policy and procedures did not contain up to date information based on current national and local good practice and protocols and were not sufficiently robust as to support, guide and protect people who used the service and staff.

There was not a robust system in place for the effective and efficient management of information. For example, care plans in the office contained too much unnecessary information such as several months' medicine administration records and the same amount of daily log sheets. Also, information was often not signed or dated to know when it had happened and who had dealt with it. The volume of information made the files difficult to manage, to access relevant information for anyone who may need it and to audit their contents. Improvements about the way people's information about them was stored and recorded needed improvement.

There was very little evidence of where the service learnt from investigations, incidents, compliments or the understanding of how the independent view of staff and people who used the service could have an influence and a value to this process.

This is a breach of Regulation 17 (1)(2)(a)(b)(c)(f),of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service worked with other agencies to ensure people were well looked after and they received the physical and mental health support they required. They shared information and concerns about people with professionals to ensure they had joined up care. They had recently worked with a hospital team so that a person could come home after months in hospital and had worked with the family to help them obtain specialist equipment to make the person more comfortable.

People knew who the managers were and were very complimentary about them. They told us, "They are always at the end of the phone," and, "They are lovely, they ring and say when [name] is running a bit late and we have a chat, it's' lovely."

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 9 HSCA RA Regulations 2014 Person-centred care People's needs were not assessed holistically and care not provided in a person centred way.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People did not receive care in a dignified way or their privacy respected.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People or their representatives did not consent to their care arrangements.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of unsafe care practices as their medicines were not being given correctly and assessments of their needs were not robust or sufficiently detailed.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have systems in place to

assess and monitor the quality of the service.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not have systems in place for the safe recruitment of staff which left people at risk.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Systems for the training, supervision and support of staff were not sufficient to deliver good quality care.