Evolving Care Limited

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Inspection report

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19 September 2017
20 September 2017
21 September 2017
11 October 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This announced inspection took place on 18, 19, 20, 21 September and 11 October 2017. The previous inspection in November 2016 found the service to be rated Good.

There was a Registered Manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are registered persons. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was present for the last day of this inspection but the provider was present throughout each day of the inspection.

Evolving Care Limited is a domiciliary care service providing personal care and support to 124 people at the time of our inspection across Crewe and Cheshire East They had 59 care staff providing care.

We checked whether there were enough staff to meet the care needs of people and found mixed views. One relative who we spoke with raised concern regarding staffing levels and consistency of staff. Another relative told us they were short staffed but staffing had improved. Other people we spoke with said they had consistent carers but there were concerns about cover when they were away.

Staff were receiving safeguarding training and could tell us what they would do if they had a safeguarding concern. There was a system of reporting alleged abuse in place however we found some allegations of neglect had not been reported to the safeguarding authority. Safeguarding concerns and investigations were not being analysed for trends to be identified.

Recruitment practices were not robust enough. We were informed by the service interviews were taking place but there was no documentation in place of interviews. We found two staff files contained evidence of a previous conviction without a detailed risk assessment. The provider took action immediately and ensured a risk assessment with control measures were in place during our inspection.

Risks were not always being identified or mitigated for people. Risk assessments were either absent or not detailed or consistent enough for staff to know how to always deliver safe care. The provider took action immediately and put risk assessments in place when we requested them such as for one person with continuous oxygen.

Incident forms were being completed in people's care plans and there was an accident book. We found no system of analysing incidents for the provider to then be able to identify any patterns emerging to reduce risks with lessons learnt.

Missed visits were not being collated or analysed. Missed calls/late/early visits were an issue for people. We viewed numerous complaints regarding timings of visits.

Most people we spoke with spoke highly of their regular care staff who provided care. We found people had not always been spoken with appropriately by staff and their dignity not always upheld. One relative expressed concern with us a carer had not acted in their relatives best interests and left them alone when they were unwell.

There was a complaints policy and system in place with a number of complaints seen in the complaints file. There was no analysis of complaints. Not all complaints were taken forward and investigated by the service.

People were being supported to drink, eat and with their meal preparation. We observed one person being provided with a choice of what to eat during our visit in their own home. People did not always receive their food and drink due to missed or late visits.

The process of obtaining consent from people in line with the Mental Capacity Act 2005 did not include specific consent for holding key codes, PRN prescribed medicines, changes to care plans or to the 30 minute waiting period either side care visits.

The care plans we checked in people's homes at the time of our inspection did not contain enough personalised information such as previous employment, preferences, likes or dislikes. When we returned on 11 October 2017 and checked new care plans we found they had improved but further improvements were needed.

There were monthly medication audits being undertaken however they had not identified the concerns we found in relation to instructions and start/end dates being absent. Governance systems did not include analyses of complaints, incidents, missed visits or safeguarding concerns.

At the time of our inspection the provider had identified some improvements were required in relation to care planning and had sourced a private consultant/healthcare professional to devise new care plans.

Additional staff had been recruited to undertake audits of rotas, care records including MARS (medication administration sheets) and reviews with people receiving a service. These new staff had not yet started in their new roles at the start of this inspection.

The provider was seeking the views of people by undertaking surveys and spot check phone calls. Staff meetings were taking place.

Staff were receiving training and the service had a training matrix in place. Their induction included shadow shifts and competency checks which were seen recorded in staff files. Staff supervisions were taking place and there was an appraisal system.

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.

Risks were either not being identified or not documented for staff to know how to mitigate risks for people.

Incidents were not being analysed with lessons learnt.

The safeguarding systems were not robust enough to ensure safeguarding concerns were being dealt with appropriately with no analysis taking place.

Is the service effective?

Requires Improvement

The service was not always effective.

Specific consent was not always being sought or documented.

People were being supported to have their drinks, food and meals but people who experienced late/early or a missed calls were not always having their hydration and nutritional needs met.

Healthcare professionals were involved in people's care.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was not always upheld due to the manner in which people had been spoken with by some staff.

People's wishes were not always being recorded.

Advocacy services were available for people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always up to date or being reviewed at the same time as the risk assessment to ensure information was

consistent.

People's backgrounds, interests, preferences, likes, dislikes or aspirations were not detailed enough to provide personalised care.

Not all complaints were being dealt with appropriately.

Is the service well-led?

Inadequate

The service was not well led.

Audits being undertaken were not identifying risks or concerns found on this inspection.

Governance systems did not include a system of tracking complaints, safeguarding concerns, missed calls or incidents for the registered manager and provider to then analyse the risk across the service.

The service had an effective system of filing and storing information.

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Detailed findings

Background to this inspection

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

This inspection took place on 18, 19, 20, 21 September and 11 October 2017 and was announced.

The inspection was partly prompted by an incident which had a serious impact on a person using the service and this indicated potential concerns about the management of risk in the service. While we did not look at the circumstances of the specific incident, which may be subject to criminal investigation, we did look at associated risks. The Commission had also received a high number of safeguarding concerns and concerns related to timings of calls and missed care calls.

The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection team consisted of one adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed all the information we held about the service including statutory notifications; they are a legal requirement to notify us of specific events which have occurred.

We talked to 10 people using the service and six relatives. We also interviewed eight staff and, pathway tracked [reviewing people's total care] two people and reviewed records for a further seven people.

As part of the inspection we contacted health watch and the local authority for any feedback in relation to the service. We also contacted commissioners of the service.

Inadequate

Is the service safe?

Our findings

We checked if people felt safe with the carers providing their care. One person told us "I feel very safe with {carer}". Another person told us "I've no real concerns at all."

Staff we spoke with were aware of their responsibilities in relation to safeguarding and keeping people safe. One staff member said "Abuse can be self-neglect, emotional, financial or psychological." The staff member was able to explain what they would do if they became aware of an unexplained bruise on a person receiving care. We checked if staff knew what to do in an emergency. A staff member told us "If someone has fallen when I get there or whilst I'm there, I would ring the ambulance first and then ring either the office or the on-call. I would ring the family myself because I'm quite close to all of them."

We reviewed staffing levels. One relative we spoke with told us they had seen an improvement as the same staff were visiting to provide care for their relative as the agency had recruited more staff who could provide care in their geographical area. Another person told us "It's an enormously average service apart from her main carer. They come four times per day and generally they are very poor at tidying up the flat except for {staff member}. They're usually short-staffed so the ones that cover are less good especially at weekends. They're running at absolute capacity. If {staff member} is not on, they're always late; for instance they have arrived at 10.45am instead of 8.30am and they never contacted us, we had to ring them."

Although the rotas we viewed detailed the times of calls with at least a 15 minute window for travel time we found a staff member's work phone we viewed detailed calls were back to back with no travel time. One staff member we spoke with told us "I don't really get travel time, but I make it work for me. I always make the rota right for me and my clients. I rearrange it because I know who prefers what time and what other appointments they've got. If, for some reason, I'm running late I would ring the on-call if it's early hours or weekend or I would ring the office at other times. If they're busy, I would ring my clients myself." Another staff member said "I get 10 minutes to go to each call but they're all quite close to each other. If I'm running late I ring the on-call and they contact the individuals and if I've been delayed for a long time they get someone else to cover the job".

We were made aware of a serious incident which resulted from a person who had not received their care at the time specified in their care plan who had then fallen and was hospitalised. An investigation undertaken by the safeguarding authority at social services found the allegation of neglect or acts of omission were substantiated.

We checked the systems in place for logging, recording and dealing with safeguarding concerns. We found not all safeguarding concerns had been identified, logged appropriately, reported onto the appropriate authorities or analysed for trends. There were two other people who we found had not been referred to the safeguarding authority upon the service being made aware by the person's relatives they had not received their care. One person we spoke with told us their relative {person concerned} had a missed call which the relative reported to the office and wanted it raising as a safeguarding issue. They were told by the office they were investigating it internally. This meant the systems in place to identify safeguarding concerns and deal

with them were not robust enough as agree protocols had not been followed.

The provider took action immediately and implemented a safeguarding tracker and analysis of all safeguarding concerns.

This is a Breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to the systems not being robust to protect people from abuse.

We checked the systems in place for ensuring people received their prescribed medication and spoke with people about the support they were receiving with their medicines. One person told us "{Person} takes their medication in a morning and they make sure she takes it whilst she's having breakfast." Another person told us "The carers hand my tablets out to me. I've got short-term memory, so I don't remember whether I've had them or not. Everything's in a book, all logged down". A third person said "They always give me my tablets in a morning".

We checked medication administration record sheets {MARS} in people's homes when we visited them. This is a record for staff to complete with information about medicines administered. We were concerned the MARS sheets we viewed for three people we visited were incomplete. We found staff completing the MARS records were writing, "refer to "NOMAD"" which is a compact disposable pack of prescribed medicines. Their MARS sheets did not have instructions, start date, end date or dosage documented on the sheets. The provider informed us they were aware MARS records were in need of improvements and they were conducting monthly MARS audit checks. There were no PRN (pro re nata which means medication when needed) guidelines for medications such as Diazepam. One person we visited had been administered three doses in one day of Diazepam and had been found by their relative to be drowsy; the relative had alerted their General Practitioner. The provider took action immediately to remedy this.

This is a Breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to the systems in place for administering prescribed medicines not being robust.

A key line of enquiry on this inspection was reviewing the times of people's care visits and missed visits. One person told us "Timekeeping's been very good, it's generally not a problem and it's particularly important to us because of her mental health issues. The same people tend to come which helps enormously". A second person said "{carer} has been out this morning but they haven't arrived as yet for my mid-day visit. They usually come between 1pm and 1.30pm so they're late today but that's not usual". A third person told us "The time does vary according to their work volume, but I never have longer than an hour to wait". A fourth person told us "We've had 5 Carers in total and we've never had any difficulty with their timings".

We asked for an analysis of all missed care visits since the previous inspection so we could look into this. We were informed by the provider they did not have a system in place of analysing missed visits. We found late or early calls were occurring at the time of our inspection.

We visited four people who received a service in their own homes. All of the people we spoke with had had problems with times of calls or missed calls. One person who we visited spoke with us with their relative present. The relative explained they had a missed care visit which was reported to the office. We viewed the care records in the person's home on the day in question and found the carer had documented they had been in the property between 1pm and 1.30pm. However, when we viewed the times on the computer system at the office we found the carer had logged in at 2.45pm for the person's lunch time visit. We were therefore, concerned the times logged on the daily sheets where not always consistent with the actual times carers were visiting people to provide care. This had not been investigated by the service at the time of our

inspection. Another person we visited confirmed their call was supposed to be at 8.30am however, on the day of our visit the carers had arrived at 9.40am, over an hour late. On the fourth day of the inspection we witnessed a call into the office from a person who had not received their morning care visit at 8am. At the time of their call to the office the carer had been 2 hours and 55 minutes late.

The provider has since implemented a more robust system of enabling office staff to view who care staff are visiting at any time of the day to identify if calls are running late. The provider told us they were recruiting for a data analyst to track care visits and the electronic system during office hours. A missed visits tracker has also been implemented by the provider since the start of our inspection.

There was a system of recording accidents in an accident book which we viewed which contained accidents which staff had whilst at work. We were concerned incidents related to people receiving care were not always being logged. We were alerted by the Local Authority to an incident. We viewed the person's care records and found they had begun to show signs of being unwell whilst being supported during a care visit. The carer left the person prior to either the person's family or medical assistance arriving and had not contacted the office to inform them. When the family arrived they found the person required urgent medical assistance and the person was hospitalised. When we raised this with the provider they told us they had investigated this at the time with the carer however, it had not been recorded as an incident or reported at the time of the incident to the safeguarding authority or to the Commission in the form of a Statutory Notification. The provider acknowledged the carer should have remained with the person until assistance arrived.

We checked to see if the service's recruitment practices were safe and viewed five staff recruitment files and associated documents. None of the staff files contained evidence of an interview. The registered manager confirmed they asked staff to complete an application form and interview on the same day as they were concerned staff would not return with an application form if they left without completing it there and then. Two staff files contained evidence of a previous conviction. The risk assessments in place were not adequate and did not specify the potential risks including what control measures were being put in place to protect people. We asked the provider to implement more robust risk assessments immediately which we viewed.

We looked into how the service managed risks for people. All four people we visited in their own home did not have all the required risk assessments for staff to know how to mitigate risks. One person's care plan stated staff were to provide catheter care but there was no risk assessment in place for staff to know what the risks were and how to reduce the risks whilst delivering catheter care. The person had been prescribed thickener and was on a soft diet however, there was also no risk assessment in place for their nutrition. Another person who had continuous oxygen did not have an oxygen risk assessment in place to ensure staff knew what to do in the unlikely event the oxygen pipe split or if the oxygen machine stopped working.

The provider told us they were aware they needed to improve their documentation such as risk assessments and care plans and had out sourced a healthcare professional to lead on this. Whilst we acknowledged this was being implemented we found information on specific risks for people were absent at the time of our inspection. The provider took action immediately and ensured specific risk assessments were put in place during the inspection.

This is a Breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to their not being robust systems in place to analyse incidents, safeguarding concerns and missed visits

Requires Improvement

Is the service effective?

Our findings

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this must be made through the Court of Protection for people living in the community. If people living in their own homes are receiving restrictive care that may amount to a deprivation of their liberty, an application must be made to the Court of Protection to ensure that restrictive care is lawful and in a person's best interests. The provider confirmed there was no one receiving a service who had an appointee from the Court of Protection at the time of our inspection.

We checked to see if people's consent was being sought in line with the mental capacity act 2005. We viewed the provider's policy on the Mental Capacity Act 2005 and their paperwork to document a MCA framework for staff to follow. We found the template documentation was comprehensive including a mental capacity and best interest's process but this had not been rolled out to be included in people's care plans at the time of our inspection.

The provider had not always ensured they were seeking regular consent when appropriate. We were informed by the provider there was a 30 minute window either side of care visits (staff could arrive either 30 minutes before or 30 minutes after the time agreed for their visit) which people using the service were aware of. The provider told us this was a verbal agreement and people's consent was sought by staff. However, there was no documentation in place to confirm people using the service where either aware of the 30 minute agreement or had consented to this. We viewed the service user contract and service user handbook neither of which confirmed people were agreeing to a 30 minute waiting period. On discussing this with the provider they recognised the need to ensure they were seeking consent in line with the MCA 2005 legislation.

Of the care plans we viewed we did not see people's consent to their plan or changes to their plan of care being sought. We also did not see a system for obtaining specific consent for example, consent to hold key safe codes to gain entry to people's homes, consent to changes to call times.

This is a Breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked into whether staff where receiving an induction and training to undertake their roles effectively. The service had a training matrix which was a record of the training staff had received and when they were due to renew their training. Of the six staff files we checked we found a document titled "Induction Training Plan Care/Support Worker" which listed with the topics covered within the induction such as health and safety, protection of vulnerable adults and the date the induction was completed by. We viewed

documentation confirming dates when the care worker undertook shadowing as part of their induction. Supervision dates were also seen in the staff files with spot check dates to assess staff competencies. We viewed training certificates included in the staff files for Safeguarding, medication administration, moving and handling, health and safety. One staff member's file we checked who had no previous experience working in care had a Care Certificate dated April 2017. This meant the provider was recognising the need to ensure staff who had no previous employment in care were receiving training which met a nationally approved standard. We found an appraisal system was in place but not all staff had received an annual appraisal.

Support with food and drink was seen documented as part of people's care planning at set times of the day. We observed support being provided with meal preparation for one person during our inspection. The staff member was aware of the person's nutritional needs.

People did not always receive their food and drink at the times set out in their plan of care due to late or missed calls. When people do not receive enough to eat and drink during the day it can lead to secondary risks such as infections, falls or increased confusion.

One person's relative we spoke with told us "{person} is very reliant on them but she's fiercely independent. They make her a hot meal, everything's ready for them, and the meals tend to be OK although it depends on the staff. She's never complained about her meals and she would". Another person told us "The meals are delivered during the day and they just heat them up for me."

Healthcare professionals were involved in people's care such as district nurses and general practitioners.

Requires Improvement

Is the service caring?

Our findings

We received feedback of concern during the inspection from a relative who was concerned about the attitude of a staff member who was asked to no longer provide care for the person. The relative said - "We insisted they dismiss one person due to their attitude. They either arrive very late or very early constantly on their mobile phone. The carer lodged a complaint to say that she {person} had hit her but we have CCTV and it proved that it wasn't the case".

Another relative we spoke with told us they had been concerned staff had not attempted to speak with their relative who was receiving care to build a rapport with them.

We were informed by another relative they were concerned a staff member had not remained with their relative who was unwell until help arrived. They found their relative unsupported which compromised their safety and dignity and did not display a caring attitude. .

The care records we viewed confirmed people were not always receiving care according to what the plan of care stated. Staff were leaving the call earlier than expected reducing the duration of the care visit. There was no explanation as to whether the person had asked the staff member to leave or not. This meant it was not always being documented what the person's wishes were during their care visit.

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

We did receive some positive feedback on our inspection. People we spoke with told us "They're always very respectful towards {person} especially when they are washing them". Another person told us "I'm very happy with my carers. They're all very nice and very respectful". A third person said "The carers are marvellous and very thoughtful. They're more friends than carers, their attitude is 100%." A fourth person told us {staff member} is very friendly". A fifth person we spoke with told us {service user's} main carer is very prompt, courteous and genuinely cares. She is phenomenal".

We checked if people were receiving care that maintained their dignity and independence. One person told us "{Staff member} is always there in the bathroom and I never feel rushed and {staff member} has time to chat."

A second person told us "They {staff} make my breakfast and help me to wash. The meals are delivered during the day and they just heat them up for me".

A third person said "They help me to have a wash and get me something to eat. They always ask what I want".

Office staff undertook phone calls to people using the service to ask them if they were happy with their care. We were present when phone calls were being made during our inspection. We found care call times were

being changed to suit the person at times. One person told us "I usually just have a morning visit but this last week, I've had an evening one too because my family are on holiday."

People's independence and right to choice was being upheld. We were present when a carer was asking a person what they wanted to choose for their lunch. The carer spoke respectfully and in a warm and friendly manner.

We checked if advocacy services were being offered to people. One staff member told us "Age UK offer advocacy services". People were provided with information about how to access advocacy services within the service user handbook. The handbook stated "service users have the right to access external agents, who will act in their interests to help them solve problems, discuss concerns etc. The registered manager will be happy to provide information on local advocacy groups and other support networks".

Requires Improvement

Is the service responsive?

Our findings

Care plans we viewed were written from the perspective of the person receiving care and described the individual routine of care.

There was minimal information about the person's likes and dislikes. For example, one person's care plan stated "{person} likes to sit in an electric wheelchair during the day". Their care plan also stated they had difficulties with their communication and the person used a communication aid however there was no detailed plan for staff to know how best to speak with the person to provide the person with the optimum opportunity of communicating effectively. For example, whether to ask open or closed questions, time of the day when it is best for {service user} to communicate, whether certain topics of interest assist with communication or whether nonverbal communication was important. The care plan contained some information regarding the person including their medical history but no personalised information about the person's previous occupation, interests or aspirations.

We checked to see if people were receiving assessments when appropriate and if they were being reviewed. We found care plans in the people's homes who we visited however, all of the care plans we viewed either did not contain all the information necessary to provide personalised care or were out of date. Therefore, we were concerned about the detail of the assessments being completed and how often they were being reviewed. One person's relative told us they cancelled the service due to concerns they had not received a plan of how carers were to support {service user} with moving and handling.

One person we visited had one call per day for assisting her with showering. The care plan in the home was dated 4 March 2016 and was not up to date. It did not provide the carers with up to date information about the person's current care needs and specified they needed two calls per day. The care being provided was to assist the person in/out of their shower however there was no environmental risk assessment, mobility risk assessment or a description of what level of support the person needed. We were informed by the provider the person's needs had changed since receiving treatment in hospital which was why the care plan was out of date. Therefore, despite the provider being aware the person's care needs had changed they had not updated their plan of care in their home. Another person's care plan dated 22 March 2017 stated they required support with taking their prescribed medications however, their medication risk assessment dated 22 March 2017 (reviewed at the same time as the care plan) stated "{person} is responsible for administering and storing, ordering own medication."

Therefore, we were concerned information in assessments completed were not always accurate or documented consistently. Two people who were prescribed thickener for their drinks had contradictory information in their care plan regarding how many scoops of thickener to administer and when to administer thickener. We asked the provider to seek clarification from the person's General Practitioner and healthcare professionals involved. When we returned to the service we found an improvement in this area however, further improvements were needed to ensure information was consistent for staff. We found other assessments were missing from other people's care plans we viewed during our visits such as risk assessments for prescribed medications, choking, catheter care and for use of oxygen.

This is a Breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.due to assessments and care planning not always being accurate, detailed or consistent enough.

The provider told us they had identified their care planning needed improvements prior to our inspection and had a new template of care plans and risk assessments which were to be rolled out. This was in the process of being implemented at the time of our inspection.

We looked into the compliments and complaints held by the service. We found a compliments file with cards sent to the service thanking them for the care provided. One compliment was received by the service over the telephone from a relative. We viewed a note from the telephone conversation where the relative said "{Relative} called to thank double up care team for all they did", another compliment seen recorded stated "Special thanks to {staff name} and {staff name} for their patience and good humour, you have both been wonderful".

We looked into all complaints logged since the previous inspection and found there had been 11 complaints logged. All but one of the complaints made in 2017 were in relation to timings of calls. Three people who had made a complaint had ended their contract. We viewed letters of response to the complainants but no notes of the investigation undertaken or lessons learnt. There was no system in place for tracking complaints or a trends analysis demonstrating the service were seeking to learn from complaints made.

Some complaints had not been logged or investigated as a complaint. One relative told us they had contacted the office to raise concern regarding a late care visit and raised further concerns staff had entered an incorrect time for when they were in their relative's property to deliver care. We viewed the computer system and found an incorrect time had been entered onto the daily log sheet. This had not been investigated as a complaint or taken up with the staff member concerned; there had been no investigation into this by the service. We found another person's complaint made by the person's family included a request a safeguarding referral be made and a missed call looked into. This was seen in the person's care records we viewed. They confirmed they did not receive a response to their allegation of neglect due to a missed call. This had not been logged as a complaint in the complaints file. Therefore, there had been no investigation into this. We asked for a safeguarding referral to be made and also the family to be contacted by the service to open a complaint if the person and their family wished.

We spoke to another relative during the inspection who told us "We refused to pay until they sorted out the problems and they have to an extent apart from the lateness and the extra work placed on carers at weekends". Therefore, we were concerned people were not always aware of the complaints procedure. The service user handbook provided people with some information if they wished to make a complaint. It stated people can instigate the complaints procedure whenever they felt it necessary to however it did not set out for people how to instigate a complaint.

This is a Breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to not all complaints being dealt with, investigated or logged appropriately. There was no analysis of complaints and lessons being learnt.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post at the time of this inspection. We asked people for their views about the management. One person said "I've spoken to the office staff quite frequently and they're always very helpful. They have an emergency number and they've always answered so I've always managed to speak to somebody".

A second person told us "The management came out one afternoon to do a review which involved both of us". A third person said "It's been an excellent service. I'm totally well now so hoping to be completely discharged". A fourth person said "The firm rang me for informal feedback". A fifth person told us "I'm very pleased with the service".

We discussed the high number of complaints regarding timings of care visits with the provider who explained they had a verbal agreement with people they are to expect their calls to be 30 minutes later or earlier. However, this was not in the written contract or the service user handbook we viewed. In view of the high number of complaints about missed visits, late/early visits we would have expected the provider to be analysing timings of calls and keeping a log of missed calls.

The provider had recognised they required additional checks to be undertaken as part of their quality assurance systems and had recruited three additional staff to act as quality monitors. At the time of our inspection the monitors had not started working in this role but were due to start the following week. Their role will be to audit rotas, care plans, daily records and medication administration sheets. The provider had also sourced a healthcare professional/consultant to work within the service up to twice per month to support the provider in making the necessary improvements they had identified were needed in relation to care planning.

We asked the provider how they obtained the views of people using the service. The provider told us "The most important thing is to get feedback" and "I don't have any concerns about receiving concerns/complaints. The provider confirmed they arranged for a volunteer to undertake telephone reviews with people who use the service. We observed this taking place during our inspection.

We observed the service had an effective filing system and staff were able to locate files from archiving when we requested them during the inspection. The provider showed us their computer based quality compliance system and their ISO 9001 registration certificate dated 30 June 2017 by ACS Registrars which is an accreditation by a UK accredited certification body.

We viewed recent monthly audits of MARS sheets. The audits were being undertaken by the deputy manager. The audits we viewed were not identifying the concerns we found during our inspection. This meant the audits being undertaken were not effective in identifying the risks for people to then mitigate them. The provider told us they were reviewing their system of auditing.

On 18, 19, 20 and 21 September 2017 we raised with the provider there was no system in place to track

safeguarding concerns, incidents, missed visits or complaints. This meant the service had not been keeping a contemporaneous record to analyse any trends or themes occurring within the service. The provider and registered manager both acknowledged this and very promptly implemented a system of tracking safeguarding concerns, complaints, incidents and missed visits. Further improvements were required in order to ensure the new systems were embedded.

We found the system of recording incidents was such that an incident form was placed in each service user's care plan. There was no central logging system so the provider could not view all incidents occurring within the service. Therefore, the staff were unable to confirm how many incidents of falls, near misses, emergencies in people's homes whilst care was being provided were occurring within a six month or annual basis. The provider devised a system of tracking and analysing incidents during the inspection however, it did not include all incidents which had occurred over the past six months since the last inspection. This meant there could have been a number of incidents we were unaware of with no evidence of lessons being learnt.

The provider had not completed detailed investigations to establish root cause analyses into serious incidents and therefore, lessons were not being learnt. One serious incident we looked into raised concerns recruitment practices were not robust enough. Despite the serious incident occurring months prior to this inspection we found the provider had not considered reviewing their recruitment practices. The Commission work closely with the police and are waiting for the outcome of the police investigation. We asked the provider to review their systems in place to undertake detailed risk assessments of previous convictions or when they become aware of a new conviction.

When we returned to the service on 11 October 2017 we found these systems were now in place but further improvements were required to embed the changes. For example, there was a tracker in place for safeguarding concerns and an analysis of how many safeguarding concerns but there was no detailed analysis of what each safeguarding concern was related to in order to identify any trends occurring. The provider agreed these improvements were required.

We were informed by the provider there was a 30 minute window either side of care visit times whereby staff may be late due to traffic or due to their previous care visit running over. However, this was not seen recorded in service user contracts or within the service user agreement at the time of the inspection. This accompanied with no analysis of complaints related to timings of calls meant the service where not striving to identify the root causes of the problems related to timings of calls. The provider amended the service user contract to include details regarding the 30 minute period so people were aware from now on of the terms and conditions of the agreement. However, we did find some calls were up to two hours late or early. Following this the provider upgraded the alert system to a live system which enable the office staff to identify immediately if a staff member had not arrived at a person's home at the time expected according to the rota.

The provider has sourced additional staff to support them in making the necessary changes to improve the governance systems. The new governance systems and further improvements are needed to ensure the quality assurance systems are robust enough to ensure risks are being identified and mitigated with lessons learnt.

This is a Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to the governance systems not being robust enough

The registered manager had not consistently provided the Commission with statutory notifications when

appropriate and submitted first account reports. We had to make specific requests to the registered manager to submit statutory notifications to us. It is a legal requirement as a registered manager and provider to ensure all incidents which are to be notified are submitted to the Commission.

This is a Breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 due to the registered manager not submitting notifications to the Commission appropriately.

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 The registered manager had not consistently provided statutory notifications to the Commission of all reportable incidents or events which is a legal requirement.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was not enough detailed information in care plans such as people's backgrounds, interests, preferences, likes, dislikes, aspirations or specific risk assessments for staff to provide personalised care.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People had not always received care which upheld their dignity at all times.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Specific consent was not being sought such as consent to be supported with prescribed medication, the plan of care or changes to the plan of care.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were no systems in place to log incidents or missed visits. Risks were not always being identified or assessed.

The enforcement action we took:

We served a notice of decision

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Not all safeguarding concerns were being dealt with as a safeguarding concern. The safeguarding systems were therefore, not robust enough.

The enforcement action we took:

We served a notice of decision

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There were numerous complaints regarding timings of care visits with no analysis of complaints which meant there were no lessons being learnt.

The enforcement action we took:

We served a notice of decision

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The leadership and governance systems were not robust enough to ensure risks across the service were being managed.

The enforcement action we took:

We served a notice of decision