Care Rangers Limited

Care Rangers Limited

Inspection report

46a New Forest Enterprise Centre
Chapel Lane
Totton
Southampton
Hampshire
SO40 9LA
Tel: 023 8086 8866
Website: www.carerangers.co.uk

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Ratings

Overall rating for this service	**Requires improvement** 
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?	**Requires improvement** 

Overall summary

Care Rangers is a domiciliary care service providing a range of services including personal care for people in their own homes. There were 38 people using the service at the time of the inspection with diverse needs. For example people living with dementia, older people and physical disabilities.

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 provider is also the registered manager.

At the time of our inspection Care Rangers provided 266 hours of care per week. We found the provider had widespread shortfalls in the number of suitably skilled,

Summary of findings

qualified and experienced staff to meet people's needs. There were a significant number of missed care calls which put people at risk of not receiving the care and support they needed.

The registered manager had failed to ensure that robust recruitment checks were undertaken. Some staff had been employed without adequate measures in place to ensure that people received care from properly recruited and skilled staff. Recruitment practices were not safe and had not been operated in line with the provider's own policy and procedures.

The registered manager did not have enough suitably, skilled, qualified and experienced staff to meet people's needs. Not all staff had received appropriate and up-to-date training to enable them to deliver care and support to people who used the service safely and to an appropriate standard.

Staff were not supported and supervised. Supervision, appraisal, competency assessments and spot checks were not consistently conducted. Staff told us they had not had supervision and on occasions told us they were unsure if they were performing effectively due to the lack of support and direction.

Appropriate arrangements were not in place to manage risks to people's safety. Risks for people had not been identified or anticipated and people were at potential risk of receiving care and support that was unsafe and did not meet their needs.

The registered manager and staff were unaware of their responsibilities to support people in accordance with the Mental Capacity Act 2005 (MCA). Information relating to people's ability to consent to their care and support was not recorded and staff did not fully understand the principles of the MCA.

The registered manager did not have robust systems to monitor the quality of the service or ensure that people' care records were fit for purpose and provided staff with guidance needed. Care plans did not reflect current information to guide staff on the most appropriate care people required to meet their needs. Care plans had not always been reviewed as people's circumstances had changed.

People's care records were not personalised and did not reflect their actual needs and preferences. In some cases, care plans were not in place at all and staff told us records were not accurate due to the lack of reviews in people's care.

People and relatives told us they had little or no confidence in the service provided. The office failed to communicate effectively with people when care could not be provided.

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

Summary of findings

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. The registered manager did not take all reasonable steps to ensure the recruitment of staff employed were of suitable character to care for peoplein their own homes.

The registered manager did not have arrangements in place to manage risks to people's safety.

Appropriate arrangements were not in place to ensure that there were sufficient numbers of staff available to support people who used the service.

Relatives confirmed that in their opinion their member of family was kept safe.

Is the service effective?

Requires improvement

The service was not effective. Information relating to people's ability to consent to their care and support was not recorded and some staff members' understanding relating to the Mental Capacity Act 2005 required improvement.

Staff were not effectively supported in their role through regular supervision and appraisal.

The programme of training had not been fully effective at ensuring that staff had all of the skills and knowledge they required to help them to carry out their roles and responsibilities.

Is the service caring?

Requires improvement

The service was not consistently caring,

Some people's dignity was compromised because of excessive delays in their care being provided.

Relatives told us that their member of family was treated with kindness and consideration by staff.

Staff demonstrated a good knowledge and understanding of the people they cared for and supported.

Is the service responsive?

Requires improvement

The service was not responsive. Care plans did not reflect current information to guide staff on the most appropriate care people required to meet their needs.

Care plans had not always been reviewed when changes in people's circumstances had changed.

Summary of findings

The provider had a complaints procedure however people and relatives were not confident that areas of concern would be listened to and addressed.

Is the service well-led?

The service was not well-led. The registered manager had failed to implement a robust quality monitoring system that operated effectively to ensure compliance with regulatory requirements.

The registered manager did not have systems in place to assess the quality of the experience of service users receiving care.

Peoples call times were inconsistent and calling schedules did not accurately reflect where care staff should be at any specific time.

Requires improvement

Care Rangers Limited

Detailed findings

Background to this inspection

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

This inspection took place on 22, 25, and 26 January 2016 and was announced. We gave the provider 48 hours' notice that we would be visiting the service. This was because the service provides a service to people living in their own homes and we wanted to make sure staff would be available to speak with us.

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

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at all the notifications we had received about the service.

We used a variety of methods to inspect the service. We looked at records in relation to six people's care. We spoke with the registered manager, training manager and seven members of care staff. We telephoned and spoke with seven people using the service and nine relatives. We also visited and spoke with six people and three relatives in their own homes to obtain feedback on the delivery of their care and to view care records held at people's homes.

We received information of concern from healthcare professionals, relatives, people and whistle-blowers. They told us people were not being supported to manage their medicine safely and said the provider did not have good systems in place to assess and mitigate risks. We were advised there were not enough staff employed which resulted in people not being cared for safely. They said the recruitment and selection of new staff was not robust and told us the provider employed some unsuitable staff.

Inadequate

Is the service safe?

Our findings

The registered manager did not take all reasonable steps to ensure the recruitment of staff were of suitable character to care for people. Application forms were not always fully completed and staff employment histories had large gaps. On the first day of our inspection there was no evidence that the provider had carried out Disclosure and Barring Service (DBS) checks for three members of staff who were providing care to people in their own homes. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with people who are at risk. The registered manager was listed as one of the character references on two of the application forms. We asked them why they were listed as a referee and they told us, "I know these people. They used to work for me and came back in August and December respectively. Surely my word is ok isn't it? When asked why she had not written a reference she replied, "Oh I haven't got around to it yet". Requests for previous employment and character references had not been received or pursued. One person's application form noted, "I have listed all my qualifications on my CV". However the CV was not included in their personnel file. We asked the registered manager for sight of this document but she was unable to produce it. We immediately contacted the local safeguarding authority to express our concerns and to inform them that a number of staff were providing care to people without having received the required safety checks.

On the second day of our inspection the registered manager contacted the DBS update service in respect of one person and provided us with documentary evidence of their suitability to work with people. The providers brochure states, 'Our care workers are carefully selected, and undergo rigorous vetting procedures, including police records checks'. However the person had been providing care to adults at risk since August 2015 without any formal checks as to their suitability. The provider had failed to follow their own recruitment policy to ensure they only employed fit and proper staff to provide care and treatment. This was a breach of Regulation 19 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People consistently told us the number of missed and late calls resulting from insufficient staffing levels had a significant impact on people's welfare and safety. The provider had significant shortfalls in respect of the number of suitably qualified, skilled and experienced staff. One member of staff said, "Evening and weekend calls are a concern. There is not enough of us to go round". Another member of staff said, "I feel guilty about taking time off because I know my calls won't be covered".

People told us calls were often very late, some as much as two hours or that care staff didn't visit at all. Most of the people we spoke with told us care workers had missed calls with no warning or explanation. One person told us, "I wouldn't be able to get out of bed on my own without my carer being here, so I really value having her. But when she is on holiday I really worry because often no one will turn up and I have to call my daughter who is very busy to come and help me. On a few occasions I have been left in bed for two to three hours until my daughter could get here". Another person told us, "Evening calls and weekends are a bit 'iffy'. They don't often turn up and never let us know. Care records for this person indicated that between Jan 1 and Jan 24 2016 the agency had failed to provide care on 16 occasions. They also told us, "The care is good…….when they turn up". Another person's record showed that between 17 November 2015 and 15 January 2016 care staff had failed to visit and provide care and support on 38 occasions. The person was living with dementia and it was noted in their care plan they were 'at risk of self neglect'. Care records indicated they needed reminding to eat because they were prone to forget". A relative of another person we visited said, "It's ok generally if our regular carer calls but when she is on holiday or off sick we don't get anyone and nobody lets us know. Have a look at the notes (record of visits). Nobody called at all between the 14 and 18 December 2015 because our regular carer was on holiday. Our carer was sick between the 2 and 4 December 2015 and nobody told us so I had to get my wife up, dressed and fed". A shortage of staff meant that people were not always provided with personal care and nutrition as calls were missed. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not always knowledgeable about safeguarding and whistleblowing procedures. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. Although relatives told us that they were confident that their member of family was kept safe some staff had not received safeguarding training. They were not able to show

Inadequate

Is the service safe?

a good understanding and awareness of the different types of abuse or knew what to do if safeguarding concerns were raised. Three members of staff could not tell us which external agencies would need to be contacted. One member of staff said, "I'm not sure really. I would probably just tell my manager".

Documentation relating to the administration of medicines was not always completed. People and relatives told us medication administration records (MAR) were not always in place and said staff had not consistently signed the MAR chart to show whether medicines had been taken or refused. For example, one person's MAR showed that they had not received prescribed medication on six occasions between 12 and 22 January 2016. One of the people we visited told us, "They (Staff) give me my pain tablets when I need them". There was no medication assessment for this person and no MAR indicating when this person had taken pain relieving medication. Of the seven people employed as carers by the provider only four were up to date with medication training. People were at risk because appropriate arrangements were not in place to handle and administer medicines safely.

Appropriate arrangements were not always in place to manage assess and update risks relating to people's safety. For example, one person needed to be assisted from their bed each day using a hoist. A risk assessment for this was in place however this related to a free standing portable hoist which had been replaced in April 2015 with an overhead fixed ceiling hoist and was no longer accurate. A member of staff said, "I think I use it ok although but I suppose there is a risk because I don't know about other staff and how they use it". This placed people and staff at risk of injury because of the possibility of the equipment not being operated safely. This was a breach of Regulation 12 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

Our findings

There was no evidence that mental capacity assessments were completed. 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.

Consent forms were completed but were not consistent in people's care files and often showed other people had signed with no assessment of the capacity of the person receiving personal care. Where this had happened there was no record of any best interest's decisions having been made in order to ensure decisions were made in a manner which reflected the person's wishes and preferences. For example, in one file we saw a person's consent for administration of medication had been signed by a relative, although the person had signed themselves consenting to care. In another we saw a friend had signed consent for the administration of medicines. People had not received an appropriate and decision specific mental capacity assessment which would ensure the rights of people who lacked the mental capacity to make decisions were respected. This was a breach of Regulation 11 (1) need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us and we saw that all new staff completed an induction programme. New staff had undertaken their induction in conjunction with the Care Certificate (these are a set of introductory standards that health and social care workers adhere to in their daily working life to provide compassionate, safe and high quality care and support). The registered manager told us, "I now have a training manager who visits every week, or as required to mentor new staff through their induction and the care certificate".

There was an inconsistent approach to supervision and appraisal. Supervision and appraisal are processes which offer support, assurances and learning to help staff development. For example, four staff files did not contained records of supervision during the past 12 months. Staff files however did show that spot checks had taken place on staff during the past three months. One member of staff told us, "We don't have them anymore. We used to but the manager has been so busy covering calls she can't be in two places at once. I have however had some spot checks by the manager". Another member of staff said, "We do have chats but I don't think anything is noted down. I can't remember the last time I had supervision in the office but I did have a spot check a few weeks ago". A further member of staff told us, "I did have an appraisal last year but to be honest it took about 10 minutes and was conducted in an open office with others around. I didn't feel comfortable with it because everyone could hear". The registered manager told us, "I know it should be done but I have been out most days covering calls myself. The girls are very busy and we can't always find the time to do them but I know it is something I need to address".

Staff had not received all of the training relevant to their role. The provider's brochure states, 'The company provides quality training for the entire workforce'. Some of the people being supported by the service were living with dementia however only three staff out of a compliment of seven had completed training in dementia awareness. Training in this area would give staff a greater understanding and would promote good practice to enable and support people to live their lives fully in the community they live in. A number of staff told us that they felt additional training in dementia awareness would be helpful and would assist them to understand in more detail how people live with dementia. Only new carers who had undertaken their induction in conjunction with the Care Certificate had received training in moving and handling, basic life support infection control and safeguarding. The training manager told us, "I know we have a lot of work to do to bring things in line. One of our biggest issues are people who leave after a short period of time. It is a pull on resources. I am in the process of sourcing additional training because most people's mandatory training has lapsed. We need to address that as a priority". The registered manager was not ensuring staff received appropriate support to enable them to carry out their duties. This was a breach of Regulation 18 (2) (a) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff supported some people with meal preparation. Staff were required to prepare or heat up simple meals or serve food prepared by family members. People were supported at mealtimes to access food and drink of their choice. One

Requires improvement

Is the service effective?

person told us, “My carer comes at lunch time to prepare me a meal. I have pre- cooked frozen meals deliver to me once a week and the meals are kept in the freezer until I want them. My carer always asks me which I would like before she heats it through in the microwave”. Another person told us, “My carer will always make time to make me a hot drink before she leaves me. It does concern me because I know she is rushing to get to her next client, but I do appreciate her doing this for me”.

Staff we spoke with confirmed they supported people with eating and drinking and always offered people choices. One staff member told us, “If people were not eating and drinking, I would try to encourage them and report the concerns so we could monitor them”. People and relatives told us staff were aware of people’s health care needs and knew when to consult with families or seek medical attention if there was a problem. A relative commented, “If my relative has any health problems the carers always ring me on my mobile to let me know”.

Requires improvement

Is the service caring?

Our findings

We received mixed comments from people about the care the service provided. One person told us, "I have a lovely lady at the minute. She comes to help me to bed each night. She will always make sure that I have a drink and always asks me if I want a book or a magazine so I've got something to keep me occupied before I go to sleep". Another person said, "My regular carer is wonderful and I get on with her really well. I don't think the agency know how good their workers are because they really let them down by not supporting them or me for that matter. She does her best to make sure that she doesn't rush me but she does sometimes have to leave me a bit short of the time that she is supposed to be here with me". One relative told us, "My mother-in-law has a lovely carer who comes to see her and she can speak Urdu which is my mother's only language. We're it not for the fact that we had her coming every day we would probably have looked for a different agency by now, but my mother-in-law has become so fond of her that I would hate for her not to be here for my mother-in-law anymore". However one person told us, "I am fed up of hearing the old excuse that the carer's car has broken down every time I call the agency to find out when my carer is coming because they are running very late. Not everyone's car can breakdown can it"? Another person said, "It's a bit hit and miss sometimes. I never know from day to day if my carer will turn up. If I could rely on them arriving at the time they are supposed to, then I could perhaps organise to go somewhere on a regular basis but this just wouldn't happen so unfortunately for now I put up with not going out very often". A relative told us, "I asked for very specific times for my father's visits, for a valid reason, to supervise his nutrition and drinking, and yet it's completely ignored. How is that giving us choice and control?"

Staff told us they enjoyed their work and enjoyed spending time with people. Where possible, the same staff were assigned to care for people so that relationships could be developed over time. However the high turnover of staff meant this was not sustained for some people. One member of staff said, "It is difficult sometimes. We have had a lot of staff come and go. It is very frustrating because just when you think we are starting to get it right another crisis comes along".

People's dignity was compromised in some instances because of delays in their care being provided. Some people were reliant on staff to provide their personal care and there was a risk that their personal hygiene may be affected because of the delays in their care being provided. However, the relatives we spoke with told us they felt staff treated people with dignity and respect. One relative said, "I have no concerns, I am sure staff treat my relative properly. Another relative told us, "It (the care provided) seems to be respectful and my relative has not said anything to me to the contrary".

Staff understood the importance of maintaining people's dignity treating them with respect. Staff displayed a clear understanding of how to provide personal care in a way which protected people's dignity, such as by ensuring people were protecting their modesty when being given personal care. Staff also told us they took their role seriously and they knew it was expected that they would treat people respectfully. People were afforded privacy when they required it. For example, a member of staff told us that they ensured door and curtains were closed before starting to provide personal care. Not all the care records we viewed demonstrated the importance of providing care that was dignified and respected people's privacy.

Requires improvement

Is the service responsive?

Our findings

The providers brochure states. 'No two Care Rangers clients are the same, and neither is their care. Each of our clients has unique and specific circumstances and needs, and so each has a unique and specific care plan. Care Rangers is committed to providing exactly the right care for you and ensuring that it changes along with your needs'. The registered manager did not have arrangements in place to ensure that people were involved in agreeing and determining how their care needs were to be met. Care plans did not always include risk assessments, and descriptions of the care to be provided at each call. They did not always include any history of the person or personalised information about them. This meant that only some people had person-centred care plans. Care plans we viewed were generic and not person centred.

Care plans we were not always updated to reflect updated to reflect people's changing needs. One person's care plan was last reviewed in December 2013 whilst another person's care had not been formally reviewed since January 2014. One person told us, "I have never had anyone come out to ask if my needs are being met or if the care I receive is what I need. They are so out of date I have to tell any new carers what to do for me because you can't rely on my care book". A relative told us, "My mother's care plan isn't really very personal to her and in fact looks like they have written up just any old plan. It doesn't detail how my mother likes her care to be provided for her and I sometimes wonder how the girls manage to interpret what it says, particularly if they are new to my mother." Another relative said, "I thought I had a lot of input to my father's care plan. I sat down with him and discussed with the agency what it was that he needed doing for him before we started using them. However, when they sent me a copy of the care plan to look at and sign on his behalf, it contained virtually nothing of what I had told them and simply appeared to be written to reflect what they wanted to be doing for him rather than what we were asking for". Staff could therefore not be sure on the level of care and support required to meet people's needs.This was a breach of Regulation 9 (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a complaints procedure which detailed how people's complaints would be dealt with and what to do if they wished to make a complaint or were unhappy about the service. We saw copies of the complaints procedure which were in the service user guide in each of the six people's homes we visited. This document was however out of date and directed people to the Commission for Social Care Inspection (CSCI) if they wanted to raise concerns about the service. CSCI was replaced by the Care Quality Commission (CQC) in April 2009 as the independent regulator for health and social care. People said they did not feel confident raising any concerns or issues they had with the provider. One person said, "It's honestly not worth complaining, because in the past whenever I have aired my views, nothing has ever happened about it". Another person said, "They keep promising to make things better but it never happens so I really don't see why I should go to the bother of complaining officially because I know there won't be any change".

We received mixed feedback from people about the quality of the service provided. One person told us, "What management! I really don't think it exists because I certainly don't see any sign of it. Whenever you phone the office you just get office staff, and certainly no manager has telephoned or met with me since I have been with the agency". A relative said, "If there is a management structure, it doesn't appear to be very active because I have struggled to get anything improved at all during the time that they have been looking after my father. It is always up to me to contact them but I very rarely get any useful response back from anyone." Other comments included, "If they had enough staff, the service would be much more reliable", "Proper visible managers, proper support to clients and staff and more staff would fix a lot of their problems", "Knowing what two way communication was would help" and "The office do not ring if the carer is going to be late. I call them and leave a message and they never call back or call the emergency number, but that is rarely answered". Two written compliments had been received during 2015. One person wrote, "Thank you for your help during my time of convalescence. Both carers were friendly and efficient and I wouldn't hesitate to call on your services again or to recommend you". Another person wrote, I wanted to say a big thank you to X, X, and X (care workers), for doing such marvelous jobs. They really do care, and it shows. They are a real asset to Care Rangers".

Requires improvement

Is the service well-led?

Our findings

Care plans contained details of people's routines and information about their health and support needs however not all care plans had been reviewed or updated. Some care staff told us care and support plans were out of date and did not always contain all the information they needed to provide the right care and support for people.

Some staff showed a knowledge and understanding of people's care, support needs and routines and could describe care needs provided for each person. This included individual ways of communicating with people. One member of staff said, "It's as only because I know the person well and have been providing care to that person for a long time that I know what to do. If a new member of staff visits the information they need will not be there". Another member of staff said, "I know my clients well but the care plans really do need updating. The manager knows this but she has been covering calls for a while and I suppose she doesn't have the time". The registered manager said, "I know care reviews have not been undertaken for a while due to staffing shortages and a requirement for me to be delivering care to compensate shortfalls in staffing. I have recently appointed a new staff member who will be conducting reviews of care and quality assurance audits on a regular basis going forward. Records we reviewed showed that five home visits to people had been undertaken since December 2015 to seek their views on the quality of service and to review care plans.

Visit schedules did not allow sufficient time for travel between people and did not reflect accurately the timings of care calls. For example, one record showed a care call for one person of 60 minutes was due to commence at 9.15am. However the next call on the list for another person was scheduled for 9.30am. Another member of staffs call schedule indicated a 45 minute call was due to commence at 10.15am with the following care call scheduled at 10.30am whilst another call schedule for a further member of staff indicated a 30 minute care call at 10.15am with the next call to another person scheduled for 10.30am. One member of staff said, "It's not very organised. I don't really know what I am doing from one day to another". We viewed the visit schedules for the period 17th January 2016 – 22nd January 2016 and found travelling time between visits had not been accounted for. We also found repeated instances where one care call overlapped another. The registered manager told us, "Our care co-ordinator is new and getting used to the system. We will include travel time and not overlap calls once she is familiar with it". We could not identify from the calling systems that the service was able to assess, monitor and mitigate risks relating to the health, safety and welfare of people which arise from the carrying on of the regulated activity. This was breach of Regulation 17 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's brochure states, "One of our quality assurance officers may contact you to ask if we can come and interview you about the care you have received from us. The results of all our client interviews are compiled into an annual report. You are welcome to ask for a copy of this if you wish". The registered manager was unable to provide us with a copy of the provider's annual report stating, "I haven't completed it yet. I've been out of the office providing care". Not all the people and relatives we spoke with told us they had completed questionnaires or had been formally asked for their views about the quality of the service provided. Between February 2015 and January 2016 the provider had conducted 14 'Client Interviews' to gain feedback from people being provided with care and support by Care Rangers. We viewed all client interview returns for this period and comments were mostly positive. For example, "Very happy with usual carers", "The care I receive has always been good and "Never late". Other comments included, "The time keeping was very poor at first but since January (2015) everything seems fine" and "times not consistent occasionally". The registered manager told us that during 2015 they had provided care and support to an average of 50 people each week. Records show that during this time the provider only sought the views of 28% of people receiving care. The provider therefore could not effectively assess, monitor or drive improvement in the quality and safety of the service provided, including the quality of the experience for people using the service. This was a breach of Regulation 17 (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with had mixed views about the approachability of the registered manager. Some people told us there was poor communication between themselves and the manager. However, one person said, "There is always someone at the end of the phone that I can call on if there are problems". Another person said, "The manager will always listen if you've got something to

Requires improvement

Is the service well-led?

say". A relative told us the manager was also very supportive after a recent family bereavement. Staff felt the registered manager was supportive most of the time but occasionally was abrupt and unapproachable. One member of staff said, "She's not really supportive. She's not listening". Another member of staff said, "Im actually embarrassed to wear this uniform". Other staff we spoke with told us that they enjoyed their work and were passionate about providing good support to people. One member of staff said, "I love this job. It is going really well so far. No issues whatsoever". Another member of staff said; "It's going really well. I like supporting people and am also interested in the conditions they have". We fed this back to the registered manager, who admitted that over the past few months the job had become very stressful with staffing issues and she at times may have come across as unsympathetic.

At the end of our inspection we shared our feedback with the registered manager and spoke about our concerns in relation to staff recruitment, staff training, reviews of care and having robust quality assurance systems in place. They registered manager listened to our feedback and demonstrated a willingness to improve systems. She told us, "I know it is going to take a lot of hard work but I want Care Rangers to be an elite service which would hopefully result in people receiving a better quality of care and service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not have a sufficient number of qualified, competent, skilled and experienced staff deployed.** **Staff did not receive appropriate support, training, professional development, supervision and appraisal.**

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not appropriately assess the health and safety of people and did not take reasonable steps to mitigate risks. Staff were not appropriately qualified to meet people's needs.**

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider did not act in accordance with the Mental Capacity Act 2005.**

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider had failed to ensure peoples care was appropriate, met their needs or reflected their preferences**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not effectively assess, monitor or drive improvement in the quality and safety of the service provided, including the quality of the experience for people using the service. The provider was not able to assess, monitor and mitigate the risks relating to the health, safety and welfare of people which arise from the carrying on of the regulated activity.
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider did not have robust arrangements in place to check staff were of good character or that they had suitable qualifications, competence, skills and experience necessary to care for people effectively.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider did not have robust arrangements in place to check staff were of good character or that they had suitable qualifications, competence, skills and experience necessary to care for people effectively.

The enforcement action we took:
We have issued a warning notice in relation to this regulation.