Carewatch Care Services Limited

Carewatch (St Helens)

Inspection report

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20 March 2017
23 March 2017
16 June 2017
20 June 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 was an announced inspection, carried out on 20 and 23 March 2017. '24 hours' notice of the inspection was given because the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be available in the office. Following the receipt of additional information of concern we also undertook an unannounced inspection on 16 June 2017 and contacted people using the service by telephone on 20 June 2017.

Carewatch is a domiciliary care agency based in St Helens. It offers care and support to 300 people in their own homes including personal care. The agency is registered as a supplier of services to St Helens, Halton and Warrington local authorities. They employ 130 support and office staff.

This was the first comprehensive inspection of this service since it was registered by the Care Quality Commission in June 2016.

The service had a registered manager who had been in post since June 2016. We were advised during our inspection that the registered manager had resigned and at the time was working their notice period. They have since left their position on 9 May 2017. 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 of the Health and Social Care Act 2008 and associated regulations about how the service is run.

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 registered providers found to have been providing inadequate care should have made significant improvements within this timeframe.

The systems in place to protect people from abuse and the risk of harm were not effective. We found multiple missed visits to people had occurred in the Warrington area leaving them without personal care, medication, food and nutrition. This meant vulnerable people were at risk of neglect.

The registered provider did not have safe recruitment practices in place which were robust. Checks to ensure staff suitability to work with vulnerable adults were not consistently undertaken.

The management of medication was not always undertaken safely. Staff had failed to fully and consistently complete all areas of the medication administration records (MARS). This meant that there was a risk to people and that staff would not identify where safety was compromised and be able to respond appropriately to concerns.

The registered provider had audit systems in place for monitoring the quality of the service. These were not

fully effective as they had identified areas for development and improvement however; had not addressed the areas of concern in a timely manner. Two of the local authorities contracting with the registered provider had identified areas for development and improvement that had not yet been addressed.

Staff had not received regular supervision. This meant the monitoring of staff performance was not effective and development opportunities were not considered.

People had access to information about how to complain. The registered provider had a complaints policy and procedure in place, however recent complaints had not been responded to in a timely manner. We have made a recommendation about the management of complaints.

Risk assessments were in place and people's needs were fully assessed. These records were not all up to date or regularly reviewed in line with the registered provider's policy. This meant people may not receive the care and support which they required in line with their wishes. Daily records were documented with the care tasks undertaken and were signed by the member of staff. These records were not always fully completed and the time of the call not consistently recorded.

The registered provider had not notified the Care Quality Commission of all significant events that had occurred at the service in line with their legal obligations. This meant that the registered provider was not complying with the law.

All new staff undertook an induction process which included a period of shadowing an experienced member of staff. All staff received regular training to ensure they kept up to date with the knowledge and skills required for their role.

Staff were polite and respected people's privacy and dignity. People told us staff were kind and caring.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005 and to report on what we find. We saw that the registered provider had policies and guidance available to staff in relation to the MCA. Staff had undertaken training and had a basic understanding of this.

The registered provider had up to date policies and procedures in place to support the running of the service that were regularly reviewed.

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 provider did not have robust recruitment procedures in place. There were insufficient numbers of trained staff to meet the needs of the people supported.

Medication administration records (MARs) for some people were incomplete. Some people did not receive their medication as prescribed by their Doctor.

People were at risk of neglect due to a significant number of missed visits. This placed people at potential risk of harm.

Is the service effective?

Requires Improvement

The service was not always effective.

Supervision was not being provided to staff in line with best practice and the registered provider's policy.

People were supported by staff that had the knowledge and skills to meet their individual needs.

People's rights were protected by staff that had knowledge of the Mental Capacity Act 2005.

People were supported to maintain a healthy diet and access healthcare professionals when required.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always receive support from staff at their allocated call times.

People's rights to privacy and dignity were respected.

There were positive relationships between people and staff.

People described a kind and caring approach shown by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People knew how to raise concerns and complaints about the service and a policy was in place to support this. However, complaints were not always responded to in a timely manner.

Care records were personalised and included a person's history as well as their likes and dislikes.

Care plans were regularly reviewed to keep them up to date.

Is the service well-led?

Inadequate

The service was not well-led.

The registered provider had not informed the CQC of all significant events that had occurred within the service.

The registered providers systems had not identified significant failings within the service.

The registered provider's systems in place for monitoring and improving the service people received were not always effective.

The registered provider's policies and procedures were up-to-date and regularly reviewed.

Carewatch (St Helens)

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 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 was carried out by one adult social care inspector. The inspection took place over three days and was announced on the first two days then unannounced on the third day. On the fourth day the inspector undertook telephone calls to people using the service, relatives and staff. The registered provider was given 24-hour's notice on the first day as we needed to be sure that someone would be available at the office.

During our inspection we visited five people who used the service in their homes. We spoke with 16 people by telephone and with seven relatives. We observed staff working in people's homes when we visited. We spoke with 10 support staff, one member of office staff, and the registered manager. We looked at 12 people's care records, 13 staff records and records relating to the management of the service.

We also reviewed information we held about the service. This included any notifications received from the registered manager, safeguarding referrals, concerns about the service and other information from members of the public. We contacted the local authority quality monitoring and safeguarding teams and they highlighted some concerns regarding the service.

Inadequate

Is the service safe?

Our findings

People told us they never felt unsafe around staff, however they raised concerns that related to the number of missed calls they had experienced. Their comments included "I've had several missed calls in the last few weeks", "My calls are often late and today I didn't get my 9am breakfast call until 11.30am" and "Monday to Thursday I have a lovely regular carer but the weekend is erratic and I never know who is coming or when".

We looked at the medicines within three people's homes that we visited. In one person's home we found their prescribed antibiotic had not been given on four occasions over five days. This was immediately discussed with the registered manager who raised this as a safeguarding concern. Another person we visited was taking their medication ahead of staff arriving each morning, although we found that staff were signing the medication administration record (MAR) to show they had administered it. MARs reviewed for six people had missing information including insufficient information relating to the medication being administered and missing staff signatures. This meant there was no guarantee that people had received their medication correctly and at the right time. Sections of MARs to include the person's name and address, GP details and any known allergies were left blank. This information reduces the risk of medicines being given to the wrong person or to someone with an allergy and is in line with current guidance.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider failed to have safe and effective systems in place for the management of people's medicines.

There were not enough staff across the service to meet the needs of people that required support. Records showed and people told us that missed calls and late calls happened particularly in the Warrington area of the service. Comments from people included "Nobody turned up on Thursday night to do my call", "Carewatch have been struggling recently to cover calls, I have had staff from the Crewe office come to support me", "Since March 2017 call times have been very variable and staff are often late" and "I didn't have a call yesterday as I normally have 7.30am and they could only offer me 10.30am". People were at risk of not receiving personal care, medicines as well as food and nutrition essential to their health and well-being. Carewatch offices from other locality areas supported the service with staff to meet the needs of people using the service following our inspection visit on 16 June 2017.

People told us that they had difficulties with staff reliability when they needed to attend an appointment. Comments included "I had booked a morning call for 7.30am today which had been approved. My carer did not arrive and I called the office at 8.45am and someone from the office came out to do my call as I had an important hospital appointment" and "I have attended hospital appointments in my nightwear on several occasions due to carers not arriving in time before the hospital transport collects me".

Warrington local authority quality monitoring team highlighted concerns that the service was experiencing difficulty with covering people's calls and they were monitoring this. The registered manager confirmed an increase in staff numbers was required to meet the needs of the people they were supporting. This had not been achieved between our visits in March 2017 and June 2017. The service had experienced a very high

number of staff resignations during the year to date. Staff told us they had difficulty covering all the calls on their rota particularly during the weekend. People told us that staff completed the required tasks but did not consistently stay the required length of time. People told us their calls had become very variable and inconsistent. People were at risk of neglect due to insufficient staff to meet people's assessed needs.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider did not protect people from the potential risk of harm due to the high number of late and missed calls.

The registered provider did not have consistent safe procedures in place for the recruitment of staff. One record showed a member of staff had commenced employment in 2017 without references in place and had been working with vulnerable people for over two months before they were applied for. Another staff record showed they had commenced employment with just one reference on file and the second was not received until four weeks after they had commenced employment. A disclosure and barring service (DBS) check had been undertaken for each member of staff however; the results of these had not always been received back with the certificate number prior to staff having commenced work in people's homes. The DBS check identifies if prospective staff have a criminal record or are barred from working with vulnerable adults. Records showed that three DBS certificates were dated after the staff member's commencement of employment. Employment checks also included photographic confirmation of their identity. The registered provider did not consistently demonstrate a safe recruitment process and could not evidence that all staff were safe to work with vulnerable people.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had not ensured all appropriate checks were in place prior to staff commencing employment.

Policies and procedures were in place in relation to safeguarding adults. A copy of the registered provider's procedure was available for all staff to access within the office. Staff spoken with demonstrated an understanding of what action they needed to take in the event of a person being abused or if they suspected abuse was taking place. Staff explained that they had a responsibility to protect vulnerable people from harm and they described the different types of abuse and the signs that they may need to look for that would indicate abuse may have taken place. They described possible mood changes in a person, for example from being quite chatty to becoming quite withdrawn. Whilst staff had completed training in safeguarding vulnerable adults, some concerns had not been reported. For example four staff had not reported their concerns relating to late or missed calls.

The registered provider had a whistleblowing policy in place and staff told us they were aware of this. Whistleblowing can be defined as raising a concern about a wrong doing within an organisation.

A system was in place for the recording of accidents and incidents. Documentation was fully completed and included full details of the event and all actions taken following it. The information was reviewed by the registered manager and also forwarded to the organisation's head office. This meant accidents and incidents were reviewed to look at any further actions required or lessons to be learnt from them.

Risk assessments were in place and were regularly reviewed. They demonstrated that risks to people and staff were considered through assessment and that identified risks were planned for. For example we saw that people's living environment was assessed in order to identify and plan for any risks to their health and safety. Risk assessments were also in place for tasks that included moving and handling, personal care, as well as activities undertaken away from the person's home. These activities included a person being

supported to undertake their shopping within the community. Appropriate risk assessments ensured that people received safe care and the correct level of intervention to meet their needs.

The registered provider had a range of policies and procedures in place in relation to safe working practices and they were made available to staff. Records showed staff had undertaken training in health and safety, fire awareness, infection prevention and control, first-aid and moving and handling.

All staff had access to personal protective equipment (PPE) which was held at the office. PPE included gloves and aprons used by staff when undertaking personal care tasks. They are used to protect people and staff and reduce the likelihood of spreading infections.

Requires Improvement

Is the service effective?

Our findings

Some people told us that they had regular staff that knew them well however others said they did not have regular staff. People's comments included "I have a regular carer Monday to Friday. When she is off everything falls apart", "On the whole the staff are good", "I enjoy the staff visiting, we have a laugh" and "I am happy and satisfied". Relatives told us "[Name] enjoys regular carers but has not had that for quite some time", "[Name] has not had continuity of staff for a long time" and "Carers know the tasks but not the person". It is important that people have regular staff that know them well, have the right skills and knowledge for the role and understand their individual needs. People told us how important continuity of staff was to them as this offered them reassurance and gave them confidence in their staff.

Records within staff files did not consistently demonstrate that regular supervision had taken place with all members of staff. Staff told us they were unsure how often supervision should take place. Four staff told us they had not received office based supervision for over 12 months. Of the records we reviewed 50% had not received supervision within the last 12 months. The supervision and appraisal policy stated that each member of staff should have, one office based supervision, one field based observation, either a second office based or field based supervision or the attendance at a team meeting every 12 months. There should be one appraisal each year on the anniversary of the staff member's employment start date. Staff told us they had not received supervision recently and records confirmed this. Supervision and appraisals are an opportunity for the registered provider and staff member to review development and training needs. It would also be a setting to discuss medication issues and assess staff knowledge in this area. Supervision is a forum where staff can be held accountable for their actions and an opportunity to discuss performance issues. This meant that appropriate processes were not in place to monitor staff performance.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider failed to ensure staff were appropriately supported through the supervision and appraisal process.

People told us that they mostly arranged their own healthcare appointments with the help of relatives or friends. Within people's care plans were the contact details of their GP. Records showed that staff had contacted the GP when they had concerns about a person's health or well-being. Staff were confident that they would be able to carry out essential first-aid should it be required and call for emergency assistance.

All staff had undertaken Carewatch induction training. Newly appointed staff had completed a 12 week induction programme. Records showed during induction all new staff shadowed an experienced member of staff until they had demonstrated they had the confidence and skills to work independently.

The registered provider had a training matrix in place that showed staff training was up to date. Staff told us they felt they had sufficient training to undertake their roles. One staff member said "Refresher training is important as sometimes you forget things, it's good to be reminded". One staff member told us they had undertaken team leader training as well as a Qualification and Credit Framework (QCF) level III in social care and had been supported to do this by the registered provider. A QCF is a nationally recognised qualification

which demonstrates staff can deliver health and social care to required standard.

People, who required assistance and support to eat and drink due to their assessed needs, had a care plan and nutritional risk assessment in place. The care plan described the person's requirements including meal choices, consistency of food and drink for people that required blended meals or thickened liquids and level of assistance required. Staff had completed training in food and nutrition awareness and knew how to respond to any concerns they had about a person's diet or well-being. Records showed guidance for staff to follow from speech and language therapists. One person told us that staff supported them to manage their diabetes through their diet. Staff members supported them with their weekly shopping and encouraged them to choose food and drink appropriate to their dietary requirements.

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 the best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA and found that it was. The registered manager and staff had a basic understanding of the Mental Capacity Act. There was evidence of mental capacity assessments within the care plan files reviewed.

The safeguards that protect the rights of people by ensuring that any restrictions to their freedom and liberty have been authorised are issued by the Court of Protection for people living in their own homes and are necessary to protect the person from harm. None of the people using the service was subject to a court of protection order at the time of the inspection.

People confirmed that they had consented to receiving care and support within their homes. People with capacity had signed to say they had participated in the completion of their care plans.

Requires Improvement

Is the service caring?

Our findings

People described the staff as caring and supportive. People's comments included "Always pleasant and friendly", "Carers are all nice" and "All the staff are kind, caring and lovely". Relatives described staff as courteous, kind and always friendly. People were not always positive about the office staff that they had contact with. Comments included "Office staff don't inform me of changes", "I leave messages at the office and nobody returns my calls", "Office staff call asking if relatives can cover the calls as they do not have enough staff" and "Office staff do not make the changes I request". Whilst people's comments were generally positive we identified some areas of concern which have impacted upon the rating of this domain.

People told us they had some regular staff that visited them and that they had got to know them well. Staff confirmed that they visited some people regularly during the week and were able to develop positive relationships with them and their families. Staff explained that calls were covered differently throughout the weekend. Some staff were only contracted to worked during the week and most staff worked every other weekend. People told us that staff always apologised if they were late. People told us that there were occasions that staff only completed essential tasks and were unable to stay the full time. Two people told us that they had requested that particular staff not be sent to them again. These requests had not been followed and the staff had been rostered to visit them again on more than one occasion. This meant people were not having staff of their choice or call times as set out in their care plan.

People told us that communication from the office staff was poor and comments included "I leave messages at the branch and nobody calls back", "Office staff never inform me of changes, it is always the care staff" and "When I have contacted the office to change the time of a call due to an appointment I was told to ask the care staff if they could change it".

During our visits to people's homes we observed staff using good communication skills. It was clear staff had developed positive relationships with people and they were seen chatting comfortably with the people they supported. One member of staff told us they found their job very rewarding and loved it and another said they tried to brighten up each person's day.

We saw that staff were polite, friendly and caring in their approach to people and their relatives. Tasks were undertaken in an unhurried manner and people said they did not feel rushed. Staff were patient when speaking with people and took their time to make sure that people understood what was being said. Staff were observed making sure people had a drink before they left, a person's emergency lifeline was in place and the person's home was left secure on exit. During telephone calls people told us they were rushed on occasions and their comments included "My morning call should be an hour but staff only have time to stay for 30 to 45 minutes and this isn't long enough". We spoke to the registered manager about this and they explained they were having some difficulty monitoring the length of time staff stayed at a call and this was under investigation by their IT specialists.

People said that some staff asked if there were any tasks that they needed support with in addition to the routines described in the care plan. People told us that staff always greeted them on arrival to their property

and entered by the agreed means. For example, key safes were used at some people's properties, as the person was unable to answer the door.

Staff had received training in relation to privacy and dignity, person centred care, equality and diversity, and communication. We observed that staff respected people's privacy and dignity and asked permission before undertaking any tasks. Staff were able to give examples of how they maintained people's privacy and dignity. This included closing blinds or curtains, knocking on a door before entering and ensuring personal care was provided in a personal setting.

The registered provider had an advocacy policy and procedure in place that included details of local organisations that offer an advocacy service. An Advocate is an independent person who supports and enables people to express their views and concerns, access information and services as well as defending people's rights and responsibilities. The registered manager told us that no one currently using the service required support from an advocate. They did however say the information was readily available to people should they need it.

We saw compliments had been received by the registered provider about the service. Comments within these included "Thank you to all of you for the care and support you gave to dad in the last few months. He thought very fondly of you all and we were very fortunate that you were around to help us through this time. You are all a credit to your profession" and "We just wanted to let you know what a great job [Staff] is doing for our dad. She is always kind, cheerful and really thinks through what needs doing for him and does it, despite how difficult our dad can be".

People's confidentiality was maintained. Records that contained personal details were stored securely in a locked office environment.

Requires Improvement

Is the service responsive?

Our findings

One person we visited told us "The service is not fit for purpose at the moment". People's comments when we spoke to them on the telephone included "Very dissatisfied with Carewatch", "I have raised two complaints recently with Carewatch due to the deterioration of service throughout this year" and "I have just contacted the local authority to complain as I am so unhappy".

The registered provider had a policy and procedure in place for managing any concerns or complaints. One person told us they had complained on at least four occasions about staff arriving at their property smelling strongly of cigarette smoke. The person said they did not feel that they had been listened to or that their complaint had been taken seriously or resolved. We raised this person's concerns with the registered manager who told us they were following the complaints procedure to investigate this. Many of the complaints received recently related to late and missed calls, incorrect invoicing and staff attending calls that had been identified by people as unsuitable.

Complaints records showed that concerns had not been consistently responded to in a timely manner and investigated in line with the complaints policy. The registered manager had been absent from the service for a number of weeks and complaints were not investigated or responded to in their absence. The registered provider's policy states that all complaints must be responded to in writing within 3 working days and investigations should be concluded within 20 working days. The registered manager agreed to investigate all of the concerns and respond to each individual as soon as possible. Previous records showed actions had been taken and outcomes were recorded and these had been fed back to the complainant.

This is a breach of Regulation16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider did not investigate and respond to complaints in a timely manner.

People's needs were assessed prior to them using the service by a suitably qualified member of the senior care team. People and where appropriate their families were involved in the preparation of their care plans and descriptions of how their needs were going to be met. Staff told us the care plans were important to ensure they knew the support a person required if they had not visited them before. People's life history, likes, dislikes and preferences were reflected within their care plans. In addition to people's care plans there was also an additional document that included key information about a person. For example, I enjoy chatting, I like to be presentable, I enjoy food and have a good appetite, my husband and son have passed away and I enjoy watching gardening programmes.
The completion of people's care plans was variable. Three care plans were very detailed and gave sufficient detail for staff to have a good understanding of the person and the support they required. Two care plans did not hold sufficient information for staff to know the support the person required. These plans also required updating as they were not on Carewatch documentation. The registered manager stated they would ensure they were immediately reviewed and updated. Comments from relatives included "Staff know the tasks required, not the person or the important detail" and "Staff often don't know the basics about [Name] and will ask where my mum is when [Name] is my wife".

A review of a person's care was undertaken annually or sooner if required, for example when a person had experienced a change of need. We saw one person's mobility needs had deteriorated resulting in the need for moving and handling equipment to be introduced. Records showed a review had been held that included the person and the local authority to discuss the person's changing need. Following this the person's package of care had been amended to take account of the changes including any risks.

Inadequate

Is the service well-led?

Our findings

Some people who used the service, relatives and staff described the management team as approachable, supportive and accessible. These people's comments included "Management are approachable and understanding" and "Office staff are responsive to any issues I have". Comments from other people who used the service, relatives and staff included "There is no management support or back up", "Communication is very poor" and "I know nothing about the company I work for".

The service had previously been registered with the CQC under another name and had been taken over by this registered provider in June 2016. Staff told us the transition had been disorganised and the communication by the registered provider had been very poor. Staff stated the transition had also been very difficult due to changes to working systems, lack of essential equipment including computers and confirmation of contracts not being received until one week before the transition took place. A representative of the registered provider and the registered manager confirmed the difficulties that had been experienced during the transition. People told us they had retained some of their regular staff team and that communication about the transition was minimal. People told us they did not have regular staff at the weekend and did not know who was visiting or when as it was so variable. One person told us there had been a negative impact on their support package. The registered manager contacted this person to address their concerns and discuss their support package.

The service had a registered manager in post that had been registered with the Care Quality Commission (CQC) since June 2016. We were advised during our inspection that the registered manager had resigned and was working their notice period. We were later informed that they left their position on 9 May 2017. We have not received the required notification for this to date. We were not formally advised of the registered provider's management arrangements for the running of the service during an interim period until the recruitment of a new manager took place.

The systems and processes for the monitoring of medication and medication administration records (MARs) were not effective. They failed to highlight that MARs did not include important information about people, their medication and instructions for use. This put people at risk of receiving unsafe care and treatment.

There were systems in place to assess and monitor the quality of the service. These included checks on people's care and staff carried out at various intervals by the registered manager, registered provider and a representative of the registered provider. However they were not fully effective as they had identified areas for development and improvement, but failed to take prompt action to improve ineffective medicines recording processes, late or missed calls and lack of staff supervision.

The registered provider had not ensured there were sufficient staff to meet the needs of the people supported. The rostering system was not robust as there had been a high number of missed calls. People had not consistently received their calls at the allocated time.

Staff completed a written record detailing the care and support they had provided to the person at the end

of each visit. These records allowed staff to detail tasks completed as well as any concerns raised and who they had been reported to. The completion of these records was variable in quality. The registered provider audited 10% of all care note records. The audits highlighted when staff had used blue pen or missing signatures but did not action missed calls, missing call times or if staff only recorded minimal information rather than factual detail of the visit. As actions were not always highlighted and completed they were repeatedly happening and improvements were not made. The local authority had highlighted this at their quality monitoring visit.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider's systems in place to assess, monitor and improve the quality and safety of the service provided were not always effective.

Registered providers are required to inform the Care Quality Commission (CQC) of certain incidents and events that happen within the service. The registered provider had not notified the CQC of arrangements that had been put in place for the management of the service until a registered manager was in post.

This is a breach of Care Quality Commission (Registration) Regulations 2009 (Part 4) Regulation 15 as the registered provider had not notified the CQC of events that had occurred within their service.

The registered provider had not notified the CQC of an insufficient number of suitably qualified and experienced staff to meet the needs of the people supported.

This was a breach of the Care Quality Commission (Registration) Regulations 2009 (Part 4) Regulation 18 as the registered provider had failed to notify the CQC of events that could affect the carrying on of the regulated activity.

At the time of our inspection the management team consisted of the registered manager and a team of care coordinators. The care coordinators role included preparing staff rosters, ensuring people's calls were covered, undertaking observations of staff within people's homes, supervision of staff and speaking to people using the service by telephone and in person. Staff were aware of who their line manager was and who they should contact to seek support and advice from at any time.

Staff spoke positively about the new manager on 16 June 2017 however, expressed dissatisfaction with the registered provider. Staff described not understanding the company they were working for, its vision or values. Staff appeared motivated to support people but all staff spoken with described insufficient travel time between calls and not enough staff to cover the calls. Some staff described feeling demoralised and exhausted from the number of calls they were doing without breaks. They described communication as poor between the registered provider and staff and also co-ordinating staff. We discussed this with the registered provider who stated they would immediately begin to address the issues raised.

The registered provider had policies and procedures in place that staff were able to access from the office for guidance within their roles. These were up to date and regularly reviewed.