Essex Cares Limited

Essex Cares West

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out this inspection by visiting the registered office for Essex Cares West on 2 March 2016; Between this date and 17 March 2016, we spoke with care staff, visited and telephoned people who used the service to get feedback about the service. We gave the provider 48 hours' notice that we would be visiting the office to make sure that the appropriate people were there during the visit.

Essex Cares provides personal care to people in their own homes. At the time of inspection up to 130 people were using the service at Essex Cares West and some people were vulnerable due to their age and frailty, and in some cases have specific and complex health care needs.
We completed this inspection after receiving concerns about missed and late visits and people being left without care and support. Concerns included people's personal care needs not being met; people not receiving their medicines at the prescribed times, and in some cases people being unable to access food and drink because of the lack of support.

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.

The service provided're-enablement' support to people in their own homes usually for a period of 6 weeks. Re-enablement is a service that supports people to rebuild their confidence to cope at home following their discharge from hospital. At which point the person is 'reassessed' and either leaves the service having achieved their agreed independency levels or if they required on-going support they may be transferred to an alternative provider. However if suitable alternative care provision cannot be sourced the person will stay with the service under their other contract 'Resource of last resort'. This was an additional contract required the service to take care packages for people where the Local Authority had been unable to secure the required care provision.

There has not been a registered manager in post since August 2015. An acting Manager was in post at the time of our inspection but had not submitted an application to register yet. 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. You can see what action we told the provider to take at the back of the full version of the report.

Although people told us they found the staff who delivered their care to be respectful and kind, many people had experienced both late and missed visits which had led to some people missing their prescribed medication and impacting on their health and wellbeing.

We checked how the service followed the principles of the Mental Capacity Act 2005 (MCA)
The MCA governs decision-making on behalf of adults who may not be able to make particular decisions. The requirements of the MCA were not being followed. The provider failed to protect and support people safely due to ineffective and incomplete recruitment practices and insufficient staffing levels to ensure people's health and welfare was met. Staff did not always receive regular support and supervision from their managers.

The provider failed to support and supervise people safely and effectively to take their medicines. Not all staff had received up to date training or supervision of their practice in relation to administering medicines or had their competency assessed. The provider had a procedure for handling complaints, comments and concerns but failed to ensure that complaints were handled effectively and in a timely manner. People and their relatives told us that most staff were caring and staff we spoke with had a good understanding of abuse and how to raise any concerns. And there were safeguarding policies and procedures in place. However, these were not being implemented and some safeguarding concerns were not recognised or addressed.

The provider had ineffective management and quality monitoring systems in place that failed to identify serious errors and omissions in the monitoring of missed calls, which placed people at risk of serious harm.

You can see what action we told the provider to take at the back of the full version of the report.

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.

There were insufficient numbers of staff employed at the service to meet the needs of people safely.

People's medicines were not managed safely.

The provider failed to recruit staff in a way that ensured that they were suitable to work with vulnerable people.

People did not receive their care and support as planned as staff were not effectively deployed to provide the care.

Is the service effective?

Inadequate

The service was not effective.

Staff did not receive training relevant to their roles and did not have their competency assessed.

People had not always been supported to eat and drink sufficient amounts to help them maintain a healthy balanced diet.

People were not supported to make choices about their care and the provider did not always respect people's preferences.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were not always respectful of people's privacy and dignity.

People were not encouraged to make decisions about their care and support.

People were not encouraged to express their views about the service that was provided to them.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs were not always met in line with their individual care plans and assessed needs.

People's care plans did not reflect current information to guide staff on the most appropriate care people required to meet their needs.

Complaints were not adequately recorded, investigated or responded to.

Is the service well-led?

Inadequate

The service was not well led.

The service did not have consistent management from a registered manager.

There was a lack of communication between people, the management team and care staff.

The systems in place to monitor, identify and manage the quality of the service were not implemented effectively.

Essex Cares West

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was the first inspection carried out since the service was registered with the Care Quality Commission on 21 May 2014.This visit to the office took place on 2 March and between the 2 March and the 16 March 2016, people and staff were contacted to obtain feedback about their experience of receiving care or working for Essex Cares West. The inspection was carried out by three Inspectors.

Three inspectors visited the office and spoke with people using the service and staff. The visit was announced. We gave the provider 48 hours' notice of our intended inspection to ensure appropriate senior staff would be there to support us with the inspection. Before our inspection we reviewed information we held about the service including statutory notifications relating to the service. Statutory notifications include information about important events which the provider is required to send us.

As part of the inspection we spoke with 21 people who used the service, eight members of staff, one manager, one director and the head of quality and corporate governance. We viewed 12 people's support plans. We looked at staff recruitment records. We reviewed safeguarding records, comments and complaints records. We looked at quality monitoring records as well as staff support documents including individual training and supervision records. We also reviewed records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

Most people told us they felt safe when the care staff visited. One person said "Yes I feel safe. The staff are caring." Another person told us, "Yes I feel safe, always."
There was a safeguarding policy in place and staff were able to describe different types of abuse and knew the procedures in place to report any suspicions or allegations. The acting manager was familiar with the process to follow if any abuse was suspected; and knew the local authorities safeguarding protocols and how to contact them. One staff member told us, "I would report to the office or the Care Quality commission if I needed to."

However, people did not always receive safe and appropriate care that met their individual needs, for example, in relation to their personal care needs. People told us that they often did not know who was coming to carry out their visits and that some visits were missed and late. People also told us how missed calls impacted on them and their wider family. One person told us, "Morning calls are very late; my '(family member) goes out at 11.00 to day centre and last week no-one turned up at all." This meant the person was unable to attend as they were waiting for support with their personal care. Another person did not receive an evening call and did not receive personal care or a meal until the next morning. Records showed that one person had not received personal care on several occasions as only one care worker arrived to support them with personal care instead of two as required for their safety, the records indicated that this left the person distressed.

One person missed a morning visit and a relative found the person very distressed and still in bed, no contact had been made to inform the relative that the call had been missed. Another person was not supported with personal care or helped to go to bed and on one occasion the care staff supporting one person's evening visit call arrived after midnight. In January 2016 there were 11 occasions people were not assisted with personal care or with providing food and drink, this meant people did not always receive safe and appropriate care that met their individual needs and placed people's safety at risk.

One person had been found on the floor by relatives and taken to hospital, it was noted in records that a failure in communication had contributed to this person not receiving a service following discharge from hospital.

People did not receive their prescribed medications at the required times and medication was not being safely managed to ensure people's wellbeing. We looked at the Medicine Administration Records (MAR) for five people and saw there were many gaps in the recording of the medicines. We could not tell from the MAR chart whether the medicines had been given to the person or not on those days. The missed visit record also recorded 11 occasions where medication had not been administered. We discussed this with the acting manager who had not identified these gaps and had not taken the correct measures to make sure this person was supported safely with their medicines.

There was no clear process for identifying this and the provider did not follow their own medication policy that clearly states all medication errors should be investigated and reported appropriately.

One person told us, "They couldn't care less about giving me my medication on time."
We also found that the service had failed to provide a visit to one person where it was important for them to be supported to eat before prescribed medication could be self-administered, on the following visit the person was found unconscious and admitted to hospital.

There were not always sufficient staff members available to meet people's needs safely. The acting manager told us that although they employed 29 staff, they also heavily relied on the use of agency staff to support people, at the time of our inspection the service was using 26 agency staff. The use of agency staff was 'block' booked in advance and was commissioned in shifts, for example 7am-2pm and 4pm-11pm. We saw from rotas that the hours were not utilised efficiently as there were gaps where agency staff did not have visits to cover during their 'block booked shift'. However at times of peak demand in the morning and evening we saw that visits were sometimes not covered and these were recorded either as late or missed visits.

The acting manager told us that they had contingency plans and utilised all available resources but once they had utilised all their resources they could not always cover some of the remaining visits and these were missed visits, this meant that the contingency plans were ineffective and staffing levels were not sufficiently flexible to meet people's individual needs.

Staff also confirmed that visits were missed. For example one care worker informed us, "People don't always get their care on time and morning calls can go on until 12.00."
" Another member of staff told us, "We do not get travel time and calls were added to my rota, when I called to tell them I was struggling they just told me to do my best."

Staff recruitment checks were inconsistent and not in line with the recruitment policy. For example in one file we reviewed the application form was missing so it was not possible to check if a full employment history had been obtained. The policy said at least two references were obtained and required certain information to be included. However the references we reviewed did not contain the required information and no further checks had been made. In another file we reviewed there were no interview notes. We found files also contained historic information which was not relevant and suggested to managers that this should be archived to assist in navigating to current and relevant information.

These failings are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Staff told us how they gained consent from people before providing care and support. One member of staff said, "I ask people what they want." And "I talk to people about their care."

Most people had signed their care plans to indicate their consent. However, in some cases consent forms had been signed by relatives and the reason was not clearly recorded. When someone is unable to consent the Mental Capacity Act (MCA) 2005 applies. The MCA is a law to protect people who may lack capacity to make decisions and it sets out what processes must be followed in these circumstances. Staff received training in this, and showed they had a good understanding of it, but the records did not always reflect that it had been followed.

There were no records of assessment or conversations regarding mental capacity in any of the care plans that we looked at. We saw some consent forms were included; however, these were not consistent in people's care files and on some occasions were signed by other people, care records did not record the reason other people had signed. We did not see any recorded assessment of individual's mental capacity or 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.

People who used the service had not received an appropriate and decision specific mental capacity assessment which would respect the rights of people who lacked the mental capacity to make decisions.

These failing are a breach of Regulation 11 HSCA 2008 (Regulated Activities) Regulations2014, Need for consent.

Staff had not always received training in a planned way to help them to perform their roles effectively. Staff told us and records confirmed that staff had received some training. However training was not always consistent. For example the training matrix detailed all the training staff had received and what was planned for the future. However when we reviewed staff training records within their files we were unable to see supporting evidence to demonstrate that they had actually attended the training, what the training covered or the duration of the training. During our visits to people's homes we saw evidence that medication administration records were not being completed accurately, which demonstrated that medication training was not always effective.

The management team told us staff received one to one supervision, and attended regular team meetings. However we saw from records that the team meetings had not provided effective support for staff as they focused solely on the needs and review of people they supported. The acting manager told us they had recognised that staff were not being supported effectively though these meetings and were changing the focus of staff team meetings. Likewise we saw that although there was a robust and comprehensive supervision policy and procedure in place. The procedure was not implemented effectively. For example we saw supervision notes which consisted of a couple of lines and did not follow the supervision policy guidance. This outlined topics for discussion through supervision which included a review of: 'my

performance', my 'objectives' 'values and behaviours' and communication & support'. We saw evidence in supervision records that staff did not receive the support that was laid out in the provider's supervision policy guidance. One staff member told us that she had made several calls to the office to request a change to a person's care package but had not been responded to. Another member of staff told us, "The way the rota is organised, I never get a break there is a lack of communication."

These failings are a breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014, Staffing.

Most people told us that they liked most of the staff who cared for them and that they knew what they needed and how they wanted to receive their care. One person told us, "Yes I am quite able but they did what I asked." Another person said, "They are all nice people and do what they have got to do." Most people told us that staff were helpful and always ensured that they had access to drinks and snacks before they left.

We found people who had been the subject of a series of missed or late visits were at risk of receiving inadequate amounts of food and fluids. We found that one person had not received a lunch visit so did not get any food or drink from breakfast until the tea time call.

A further seven people, who all lived on their own and required the support of staff to provide food and drink, had a number of missed calls during January 2016 which placed people at high risk of dehydration and malnutrition.

Requires Improvement

Is the service caring?

Our findings

Some people told us that staff maintained their dignity when they provided support by ensuring they felt comfortable when providing personal care. However, some people did not feel that their dignity was protected. For example, one person told us that they had told the care staff that the water was cold but they still tried to persuade them to have a shower even though the person refused. This demonstrated that the person's dignity had not been maintained by staff.

Another person told us that they were provided with a member of staff of a different gender without prior consent. They told us they were upset and refused the care offered, they also told us that even after they had complained care staff of a different gender continued to be sent.

The records we viewed did not state if this person had been asked whether they had any preferences of who provided their care. This demonstrated that people's dignity had not been considered by the provider in the planning of their care.

People's preferences and wishes were not always taken into account and there was no effective process in place to ensure when there were changes to times or staff, people was informed in advance. People told us that they often did not know who was coming to provide their care until they arrived at the door. This had been a particular concern for females who had specifically asked the office not to send male care staff but this continued to happen. One person told us, "They either come very early or very late. They do cancel the night time ones sometime. I [got up] about 11 at night and a carer popped their head around the [bathroom] door. I had to tell them that it was cancelled. I can get worried about who's going to pop their head around the bedroom door." Another person told us, "I do not like the men coming late at night." And "I asked for female carers for [my relative] but males turned up any way."

Most people were positive about staff and whether they were caring. One person said, "There always obliging and pleasant people," and "They are very good, cannot speak highly enough."

People told us that generally, that staff were kind and knew how to support them. However much of the feedback we received from people was about the lack of continuity of staff and continuous changes of staff. Staff also confirmed that they were regularly moved around so they did not see the same people. Clearly this impacted of people being able to develop relationships and monitor their progress in terms of their reablement goals with their care staff. One staff member told us, "we see different people every day, there is no continuity and it is difficult to re-able people."

We found staff to be caring for example during our visits with care staff, they were kind and caring to the people they were supporting. One person told us their care workers "have such lovely smiles you cannot help but smile with them."

Inadequate

Is the service responsive?

Our findings

The registered provider had obtained copies of relevant assessments from other agencies when people were first referred to the service to enable them to understand the person's needs and establish if they were able to meet them. The registered manager told us the information was used to contact the person and undertake an assessment visit in order to agree how the care should be delivered. People we spoke to told us that the assessment visit did not always take place on the day that the person returned home, so care staff had delivered care without adequate assessments being in place. We saw that assessments of people's care needs had not been carried out by the provider before care was provided. One staff member told us, "I often arrive before the assessor and one person waited nearly a week before [they were] assessed."

Staff told us that the planning team who managed the rotas did not understand the care needs of people and the geography of the area, which impacted on their ability to effectively plan visits so that people received appropriate and timely care.

When we asked staff how they knew how to care for people they told us that they read the daily notes before providing care. People we spoke to also told us that when they had different care staff, they reviewed their notes before giving personal care.

Staff said they were able to feedback issues and concerns to the office team but that changes in need were not always fed back to the lead coordinator. We found examples of where people's needs had changed but that this had not been communicated back to the office so that when a change occurred people's needs were not reassessed and met. When we spoke to the manager about this she told us she was aware that this was a problem and was arranging meetings with the planning department to address some of our concerns.

Staff were not always supported in their roles to enable them to provide effective care and support to people who used the service. Staff told us they were allocated their rotas through the Business support centre (BSC), this was a central location. The assessment and planning function was manufactured at the centre and information was sent to staff who used a 'hand held device' to view the information. Staff told us they used to get rotas weekly in advance. However since the allocation function transferred to the BSC, they sometimes got the information very late, for example calls were assigned to them on the day. Staff were responsible for 'refreshing' or updating their hand held device so they had up to date information on the visits they were due to carry out. Sometimes this information did not come through, for example if they were in an area with poor signal strength. This meant that visits were not always provided at times the customer was expecting them and therefore their assessed needs were not being met.

Staff we spoke to told us that if they identified a change in a person's needs when they visited and the person required more time they would be able to provide this even if this meant their next visit maybe late.

Some people we spoke to required continued support but did not know how this would be arranged. One person told us that they had "spoken to the assessor three weeks ago and they said she would come back to

me but I haven't heard anything yet." This meant that people did not know who to contact about their move between different services.

We looked at people's records and found that details relating to people's needs, wishes or choices when they move between services were not recorded. When we spoke to the manager about this we was told that the service does not have any arrangements in place to make sure that when people move between services that their move is planned and coordinated or that they provided with information about who to contact next. This meant that people did not receive consistent planned support as they move between different services and did not know who to contact about their transition to a new care provider.

People's care plans did not all contain the person centred information that care staff required in order to get to know people and provide personalised support. People's care plans did not contain relevant information about their life history, their home and family, and things which were important to them. Care plans were generic, focused on tasks, and did not reflect the different strengths and limitation of each individual.

The process for reviewing care plans was not robust. The registered manager told us that assessor's visit people to review the progress that people are making. This was not recorded, the records we checked did not contain information about how people progressed to live independently again.

There was a risk that people would not receive appropriate care which responded to their assessed needs.

These failings are a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person -centred care.

The manager told us they had a care record that contained information about how their needs should be met together with other information about the service which was kept in their home. The care records we reviewed in people's homes did not always contain information explaining to people how they could make comments, compliments or complaints.

The provider was not responsive to people's complaints. Complaints were not always dealt with in an open, transparent and objective way. Most people told us that they knew they could make a complaint, but not everyone was clear about the process. The provider had a complaints policy and procedure, although this was not always followed in practice. The manager was unable to demonstrate how they had analysed complaints to identify trends to drive improvements in the service.

We reviewed the provider's complaints file and found there had been a number of complaints. When we reviewed care records we found that there were many more complaints which had not been subject to the provider's complaints procedure and had not been formally recorded as complaints. Not all people's concerns and complaints were explored and responded to appropriately.

The lack of consistency of care staff was a concern raised by most people. Most people told us they received different care staff daily. One person told us, "It can be a struggle constantly telling people where everything is because they haven't been here before".

We saw from complaints that this was an issue which some people who used the service had raised. The information clearly showed that some people had not had their needs met at the right times for them and that delays in receiving care had put people at risk. One person said, "They do ring to let me know but staff sometime arrive very late."
Another person told us "One staff member was so rude I sent them away. The office did not follow up to

investigate what happened".
People were not satisfied with the way the business support centre responded to them and on occasions felt that they were spoken to in an abrupt and rude manner. One person told us that they contacted the office to report a missed call but they did not get a letter or an apology, they told us "The person in the office could not be bothered with my call." Another person told us. "I usually phone them but the person on the other end of the phone is an admin clerk who doesn't know what to do. I have never had a phone call investigating what the problem was."

We saw that in a feedback survey in September 2015 quality issues such as; missed calls, disorganised office staff, problems with hand held device rota planning, no consistent staff, lack of organisation have all been identified through complaints, staff raising concerns and local authority feedback. But we saw that no action had been taken to address the concerns and no improvements had been made.

These failings are a breach of Regulation 16 of the HSCA 2008 (Regulated Activities) Regulations 2014, Receiving and acting on complaints.

Inadequate

Is the service well-led?

Our findings

We found that the systems in place to monitor and assess the quality of care were not effective. The provider was aware of some of the concerns that we had raised at the inspection but did not have the appropriate systems in place to accurately collect, record and analyse the information to take appropriate action.

The checks in place to ensure that staff were supporting people correctly with their medicines were not effective. The acting manager told us the Medicine Administration Records (MARs) were in people's homes and were not brought to the office until the person's reablement package was completed so there had not been any checks carried out. There were very few spot checks of staff delivering care and staff supervision was completed by service co-ordinators who were not supervised by the acting home manager.

We saw that records made in people's homes that recorded what actions staff had undertaken were not returned to the office until the end of the person's reablement contract, and there were no effectives systems in place to check that the care was being delivered correctly.

The acting manager could not be assured that staff were effective in their role as aspects of the manager's role such as supervisions and monitoring the quality of staff performance were carried out by the provider's service co-ordinators who were not directly supervised by the acting home manager. We asked the acting manager how they ensured that people were receiving the care that they were assessed for and we were told that there was not a system in place to do this. This meant the provider did not have systems in place to assess, monitor and improve the service to ensure that risks to the health and wellbeing of service users were mitigated.

We found that the records were often unclear, poorly organised and failed to appropriately record the service delivered. When we reviewed the daily records and MAR charts available we saw that some people had not received their medicines correctly and others had missed calls that the service had not addressed.

We found that during the month of January 2016 there were a total of 20 missed visits to people according to information the senior management team at Essex Cares West gave us. This was where nobody had turned up to provide care to the person. Additional evidence of missed visits was found in care files but this was not then matched in the recording of missed visits held centrally..

The management team told us that the structure of the contract and how work was assigned from a central point and this exacerbated the issues as they were not always able to take corrective action to put things right. Many of the missed visits only came to light following the event.

Of the twelve people's available records viewed we saw calls had been missed, medication had not been given correctly and complaints had not been addressed. There were no effective arrangements within the service to recognise and address these failings. We saw that there were systems in place to manage missed or late calls but again this system was ineffective and failed to identify, investigate or action all the concerns identified to improve the service.

The service was disjointed and not effective in delivering its objectives. Although many of the shortfalls in service delivery had already been identified by the current management team, we were unable to see any improvement to the overall service delivery. Staff and managers told us that due to the various functions of the service being deployed from a different location, when things went wrong it was really difficult to take timely remedial action.

The management team were open and transparent and demonstrated a commitment to improving the quality of the service. However they told us that some aspects of the service for example the assessment and planning aspect was 'managed' from the BSC and therefore they did not have direct responsibility for this aspect so when things went wrong it was an onerous process to try and get things sorted out. For example missed visits or where people had chosen to have a female worker this information was not always communicated effectively which resulted in people refusing a service and therefore potentially being placed at risk.

In another case the service had been discontinued and staff continued to be 'assigned visits'. Staff told us that they attended a visit and found the person had been admitted into hospital two days previously, however they had not been informed and still attended the person's home. People did not receive consistency as visits were 'assigned' to any staff who had available capacity so this meant that staff could not always monitor improvements especially to people who were being supported through the enablement service.

The 'enablement service' had no evaluation in place at the time of our inspection. So at the end of peoples 'enablement' plan, there were no checks in place to know if people had been effectively supported to achieve their enablement objectives or if the service was meeting what it set out to achieve which was to support people to achieve optimum independence following an episode of ill health or an accident.

Staff we spoke with said that on occasion they worked without breaks. Some staff felt that they were well supported others told us they had received little or minimal support and did not think the business support centre gave them the information they needed to do their jobs correctly.

The provider told us they had experienced a surge in their referrals towards the end of November 2015, due to the number of cases that required on going support which the provider referred to as post reablement hours. This was also alongside an increase in the number of 'provider of last resort' referrals.

The provider had taken action to mitigate some of this shortfall; however some rotas were not planned or produced in advance so people did not know who was providing their care.

This was demonstrated by the difference in the data from the provider and the feedback we received from people using the service. This lack of effective monitoring placed people at serious risk of harm.

There was limited information on how the organisation obtained the views of the people who used the service. Only 5 people we spoke with were able to confirm that they had been consulted or sent a satisfaction questionnaire about the service they received. This showed a lack of commitment by management to obtain feedback to enable them to put actions in place to improve the standards of care and improvements across all aspects of the service.

We looked at a previous review of questionnaires the service had received in September 2015, this review evidenced missed calls, disorganised office staff, problems with the hand held device CACI, rota planning, no consistent staff and lack of organisation in the review but the provider had not used this information to

mitigate the identified risks to people or make any improvements.

This lack of robust monitoring meant that issues of missed and late visits were not picked up and addressed in a timely way, and the poor practice continued.

These failings are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance

As part of the inspection process we identified that a number of safeguarding concerns that had been raised with the Local Authority safeguarding team. We checked our systems to confirm if the provider had informed the Commission of the concerns that had been raised and could see that only one of the statutory notifications received by the Commission related to the safeguarding's that had been raised with the Local Authority. Systems to protect people using the service were inadequate as required notifications were not sent to the Commission as required as part of the regulations.

These failings are a breach of Regulation 18 HSCA 2008 (Registration) Regulations 2009: Notification of other incidents

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 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 Registration Regulations 2009 Notifications of other incidents We had not been notified of all the safeguarding allegations and investigations as required by the regulations

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Lack of person centred care

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People who used the service 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.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use this service were not provided with safe care and treatment.

Regulated activity	Regulation

Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to make sure that people received care and treatment that was appropriate, met their needs and reflected their preferences.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance A lack of robust monitoring meant that issues of missed and late visits were not picked up and addressed in a timely way, and the poor practice continued

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to provide staff with appropriate training and supervision to enable them to carry out their duties.