Wilnash Care Limited

Wilnash Care Limited

Inspection report

Hollies House, Suite A
230 High Street
Potters Bar
Hertfordshire
EN6 5BL

Tel: 01707830037
Website: www.wilnash-care.co.uk

Date of inspection visit:
05 August 2016
08 August 2016
09 August 2016
15 August 2016

Date of publication:
12 October 2016

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 inspection took place on the 5, 8, 9 and 16 of August 2016 and was announced. The provider was given 48 hours' notice of the inspection because we needed to ensure that somebody would be available to meet us in their offices.

Wilnash Care Ltd is a domiciliary care service providing care and support to 36 people in their own homes. At the time of our inspection there were 32 people using the service.

The service had not had a registered manager in post for two years prior to our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were left at risk of receiving care and support that was unsafe and did not meet their needs. There were not enough staff deployed by the service to meet people's needs. Calls requiring two care workers were routinely attended by a single member of staff, which left people at risk of not being moved correctly. There was insufficient monitoring of call times to identify patterns or trends that may have impacted on the quality of care that people received. People's medicines were not managed or accounted for correctly and changes to medicines were not identified and included in people's care plans. Risk assessments were not detailed enough to adequately capture risks to people or control measures to minimise these.

Some staff did not have valid employment references on their files. Existing staff did not receive regular supervision nor appraisal of their performance, training or development needs. While staff had received an induction and some training, this was not regularly refreshed or updated, and there was no system in place to monitor this or plan a schedule to train staff in the future. Not all staff understood the correct way to safeguard people or what constituted a safeguarding incident. There was no training provided to help staff to understand the Mental Capacity Act (2005) and people's care plans did not include any information in relation to their capacity to make and understand decisions about their care and support. While there was some evidence of consent in place, relatives had sometimes consented on people's behalf without an assessment of the person's capacity to make their own decisions or a decision made in the person's best interest that the relative should give consent.

The service did not adequately identify people's needs in relation to nutrition and hydration. There was limited information available in people's care plans to help staff understand the foods and drinks that were appropriate for them. There was some evidence that support was being sought from external healthcare professionals as necessary.

People told us that staff were kind and caring, and staff had developed positive relationships with people. However there was not always enough information in people's care plans to provide staff with adequate

knowledge of the person. Some people felt treated with dignity and respect, but others told us this was not always observed. People's care plans did not fully reflect the extent of people's needs, and were not always reviewed if the person's needs changed. There was limited evidence of involvement from people or relatives in reviews of people's needs.

The provider's complaints policy was out of date and included incorrect information about how to make a complaint. The service did not record or monitor all complaints and the response to complaints was inadequate.

There was no registered manager in post and no application to register a manager had been made since the previous one had left two years previously. While people, relatives and staff were positive about the support provided by the manager of the service, there was inadequate governance and oversight overall which meant that systems were ineffective. There were no audits carried out to identify improvements that needed to be made. Some quality monitoring took place but there was no action taken to make improvements in response to people's feedback.

During the inspection we identified serious concerns and several breaches of regulations which put people at risk of harm. As a result we have taken enforcement action against the provider to ensure that improvements are made.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's medicines were not properly managed or accounted for. There was insufficient information documented to enable staff to carry out medicines administration safely.

There were not always enough staff available to meet people's needs. People who required a call to be completed by two staff were occasionally attended to by a single member of staff.

Risk assessments were not detailed enough to provide clear and consistent instructions for staff on how to keep people safe.

Is the service effective?

Requires Improvement

The service was not effective.

Staff did not always receive regular updates to their training and there were no systems in place to monitor this.

Staff did not receive regular supervision or appraisal of their performance.

The information contained within people's care plans in relation to their healthcare, nutrition and hydration needs was insufficient.

No training was provided to help staff to understand the Mental Capacity Act (2005).

Is the service caring?

Requires Improvement

The service was not always caring.

People were cared for by staff who had a caring and compassionate approach, but they were not always able to attend to people on time.

People were not always treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care plans lacked personalisation and detail and were not reflective of people's changing needs.

There was no evidence of the involvement of people or their relatives in the care planning process.

Complaints were not being managed or responded to correctly.

Is the service well-led?

Inadequate

The service was not well-led.

The manager had not registered with the Care Quality Commission and there had not been a registered manager in post for two years.

There were no effective systems in place for monitoring quality or auditing the service to identifying improvements that needed to be made.

The provider's policies were out of date and were not implemented correctly in practice.

Wilnash Care 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place over four days on the 5, 8, 9 and 16 August 2016 and was announced on the first day. The provider was given 48 hours' notice of the inspection because it is a domiciliary care agency and we needed to ensure that somebody would be available to meet us in their offices. The inspection was carried out by two inspectors.

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 reviewed the information available to us about the service, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. We reviewed local authority inspection records and asked for feedback from nine professionals involved with the service.

During the inspection we spoke with seven people and three of their relatives to gain their feedback. We spoke with three members of care staff, the deputy manager, manager and the registered provider.

We observed the interactions between members of staff and people during two visits and reviewed the care records and risk assessments for eight people who used the service. We checked medicines administration records and looked at staff recruitment and training records. We looked at complaints and compliments received by the service. We also reviewed information on how the quality of the service was monitored and managed.

Inadequate

Is the service safe?

Our findings

People's medicines were not managed safely and were not always accounted for on MAR (medicines administration record) charts. The provider's policy on the administration of medicines was not being followed, and the information contained within people's plans was insufficient to provide staff with an understanding of the medicines that people took and their preferred method of administration. Creams, eye drops and medicines requiring topical application were not always accounted for.

Two people had paracetamol prescribed on a PRN ('as and when') basis but there was no protocol in place to determine when this should have been given. When we asked about this for one person, the deputy manager told us, "[person] should be having the full dose every day," but MAR charts did not reflect this. We were later told that this person's family now administered this medicine, but it still appeared on their MAR chart and there was no change to the care plans to reflect this. The manager was unable to account for large numbers of unexplained gaps on MAR charts. Medicines had been entered twice for one month for one person, and there were medicines crossed out and signed for inappropriately. Medicines which had been discontinued months previously were still being included on MAR charts. There were no times to indicate when these medicines were meant to be administered. The MAR charts were not checked, audited or returned to the office on time. Consequently there was no action being taken to identify the reasons for these significant errors, or action being taken to manage the resultant risk to people.

The provider's medicines policy had not been updated since 2011 which meant that the service were not reviewing whether their practices in relation to the administration of medicines were still meeting best practice guidelines. The policy they used was not being followed correctly, for example it stated that people who required support with taking their medicines would have a care plan in place with clear information including times, dosages and instructions, including creams or other topical solutions. However there was no information in regard to medicines in people's care plans and no risk assessments in place if people had their medicines late or refused them The lack of effective systems for the management and accounting of medicines meant that people were being put at risk of not receiving their medicines correctly. When we spoke to the manager they acknowledged that the service had failed to manage people's medicines in line with their policy.

The risk assessments in place were not personalised or detailed enough to support staff to keep people safe. We looked at the risk assessments for six people and found that all of them were too basic to adequately manage risks to people's health and welfare. There were risk assessments for people's mobility for people who required support with moving and handling, but no control measures in place to help them to mobilise safely. We saw that one person walked with a frame and had suffered a broken hip but there was no information on how staff could support them to move safely. Another person had significant weakness on one side and mobilised with a frame, but there was no further information on how the risk of falls or injury could be further reduced. There were no risk assessments in place in relation to personal care, medicines, vulnerability to abuse or behaviour which may have impacted negatively on others.

During one of our visits we noted that one of the care staff attending a call was using crutches and was

therefore unable to provide physical support to the person despite this being part of their agreed package of care. No assessments were in place to address this situation which placed the person and the staff member at potential risk.

The failure to manage people's medicines safely and the inadequate risk management was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person said, "They're struggling with people at the moment. They're supposed to come in at 11 and they haven't been in until 12 and once as late as 1pm." A relative told us, "On occasion they can't provide double-ups for [relative] because they haven't got enough staff." We were told by the manager that two people who required calls to be carried out by two care workers to mobilise safely had occasionally received care from one member of staff. The records of their call visits confirmed this, and the provider told us that this had occurred on 54 occasions during the six weeks prior to our inspection. The manager told us that it had been agreed with the local authority for only one person to attend these visits, but there was no evidence of this in the person's care plan. The assessments in place clearly stipulated that two carers were to attend all calls. No risk assessment had been created to minimise the risk of harm to the person in case of a single carer failing to carry out their duties effectively. The lack of formal agreement or processes to ensure that enough staff were available to attend people's calls left them at an unacceptable level of risk of harm.

We looked at the service rotas for the previous four weeks and saw that some calls that required two care workers had been planned with only one member of staff. There was no policy on late or missed calls, and the managers could not provide a list of the number of calls that were late or missed because no analysis was carried out of the system used to monitor this. Sometimes staff were only given their rota the day before they were due to attend to their calls. The service was not effectively planning ahead to anticipate any shortfall in staff. This posed a risk of people being left without care. A staff member told us, "We are short staffed. We make do and get by, but we're always one or two down." The manager told us they were not accepting any new referrals due to staff shortages, but the issues identified during the inspection meant that there were not sufficient levels of staffing available to fully meet the needs of people's already using the service.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a recruitment policy in place. We looked at the staff files for six members of staff and saw that references and DBS (Disclosure and Barring Service) checks were being sought as required. DBS is a way of employers checking to see whether staff have any prior convictions or concerning information on file to enable them to make safer recruitment decisions. However there were not always valid employment references on file from previous employers, and two of the files we looked at contained only character references. This meant that the service could not always be certain that staff had the necessary skills and experience to carry out their duties.

People using the service told us they felt the care provided by staff was safe. One person said, "They keep me safe, no doubt about it." A relative we spoke with told us, "I need to know that [relative] is safe and happy and well and they've given me that peace of mind."

The staff we spoke with understood how to keep people safe, but were not always aware of how they might safeguard people if they felt they were at risk of abuse. One member of staff described the ways in which they kept a person safe, and said, "I would always check to see how they are, check for any marks on them, follow the care plan and report anything I was concerned about to my manager." However staff were not

always aware of who could speak to if they needed to raise any safeguarding concerns. One member of staff said, "I'd speak to the manager, or maybe the GP." The provider's safeguarding and whistle-blowing policy was out of date. While staff did receive training in safeguarding, this was not regularly refreshed.

Requires Improvement

Is the service effective?

Our findings

While staff were positive about the training they received, the lack of oversight in this area meant that we could not be sure that all staff had received training appropriate to their role. A relative told us that they did not believe that all staff were able to operate a hoist to move people safely and often had to ask other members of their family for advice. While all staff had received training in manual handling, there was no information provided of how this was being updated or refreshed, and no observations took place to assess staff competency following their induction. Training records in staff files were not up to date, and therefore we could not be certain when training had been completed. In four staff files we saw that the training record indicated that no training had been completed since 2013, although there were some certificates from 2014 and 2015. In one staff file there was no information provided of training having been completed. We asked to see a training matrix but were told this was out of date and was not being used to monitor staff training needs. This meant that the manager was unable to provide us with an accurate list of the training that staff had received and how their knowledge was being continually refreshed and updated.

We saw evidence that staff had completed training that the provider considered essential, such as safeguarding, health and safety, medicines administration and moving and handling. However the lack of update training meant that staff could not adequately describe the measures they would take to safeguard people from risk of harm. Staff did not receive training to help them to understand people's primary needs- for example the service provided care some people living with dementia, but staff not receive training to understand this condition. People's care plans included information about behaviour which may have impacted negatively on others, but no training was provided to staff to help them to develop approaches to manage this safely. This meant that staff were not always equipped through their training with the knowledge and skills to deliver care for people safely.

Staff underwent an induction program when they first started with the service, but did not receive regular supervision or appraisal of their performance. A member of staff we spoke with said, "We have a kind of supervision all the time, as we talk about things. In terms of formal supervision though, it's probably about once a year." We looked at six staff files and found that only two had received a supervision in 2016, and that the other four had received no formal supervision since 2014. Only one member of staff had received an appraisal in the previous year. This meant that staff had not received regular appraisal of their performance nor were their training and learning and development needs identified and addressed. Consequently people were supported by staff who may have lacked the necessary skills to do so effectively and may have been delivering support in a way that did not reflect current guidance.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

No member of staff employed by the agency had undertaken training in relation to the Mental Capacity Act (2005) and how this affects people's capacity to make decisions and choices for themselves. 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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. Applications to do this must be made to the Court of Protection. There had been no applications made to the Court of Protection for any person who used the service.

There were not always sufficient systems in place to assess whether people had the capacity to consent to their care and treatment. In some care plans relatives had signed to indicate consent, but there was no accompanying capacity assessment to explain why people could not consent for themselves, or best interest decision made in relation to the person's capacity to consent.

The people we spoke with told us that staff did ask for consent prior to delivering care. One person said, "They wouldn't do anything without my say-so." A relative told us, "We've had discussions with the service about what [relative]'s needs are and how they would give their consent. The staff always ask [relative] before they do anything." The staff we spoke with understood the principles behind consent and told us they would always make sure people were aware of what they were doing and why. However the lack of training or clear information contained in care plans meant that there were no clear protocols or guidelines for staff to work to when assessing whether people had the capacity to consent.

Information relating to people's dietary requirements lacked sufficient detail, which meant that people were at risk of having their needs in relation to nutrition and hydration neglected. For example we saw in one care plan that the person "can have difficulties swallowing liquids", but there was no further detail on how to manage this risk. The person's nutritional risk assessment stated 'carers to provide preparation for food and drink and encourage', but the person's daily notes seemed to indicate that they were on a pureed diet and needed significantly more support with eating and drinking. The risk assessment made no reference to the initial assessment that the person had difficulty swallowing liquids. Another care plan mentioned that a person had a 'soft diet' and 'sometimes problems with swallowing', but there was no further detail in regard to their likes or dislikes, the support they needed with eating or how to mitigate any associated risk with their possible difficulty when swallowing. The person used a food supplement that was not included on their MAR chart.

People told us that the service were effective at identifying their healthcare needs. One person said, "They're good at noticing things. If I've got a rash or something they'll always highlight it and call somebody in. They encourage me to take better care of myself." People's care plans included some basic information about their healthcare needs and conditions, and we saw evidence that appropriate referrals were made when concerns had been identified in relation to people's health.

Requires Improvement

Is the service caring?

Our findings

While people and their relatives told us that staff were caring, this was frequently undermined by inadequate oversight and governance in the service which resulted in people not always receiving their calls on time or the correct number of care staff to meet their needs.

The information contained within people's care plans failed to include any details in relation to people's backgrounds, social histories or likes and dislikes. This meant that while some long-standing staff had formed positive caring relationships with people, they were not always given sufficient information to understand all of their needs. Because there was no evidence of involvement in care planning or review, and no action taken in response to the feedback from quality monitoring, people were not always actively involved in making decisions about their care and support.

We received mixed responses when we asked people and their relatives whether they felt they were treated with dignity and respect. One person said, "They're the most respectful carers you could possibly ask for." However a relative told us that they had concerns over how staff were observing their family member's dignity and had left wet pads on the floor and forgotten to close curtains when delivering personal care. One person who was due to receive two members of staff for their call would often receive a single member of staff and then have to wait for a second member to arrive if they required personal care. They were therefore left for an unacceptable period of time requiring support as a direct result of the service being unable to provide adequate staffing levels. This meant the person's dignity could have been compromised.

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

The staff we spoke with demonstrated good understanding of dignity and respect and could tell us about the ways in which they observed this for people. One member of staff said, "I would always tell them what I'm doing, be sensitive to their needs and give them privacy. I try to think about what it would be like if it was me." However there was no information in care plans in relation to dignity and respect and no outcomes for people to establish ways in which staff could actively promote this when delivering care. There was no information included as to how people could be encouraged to maintain and develop their independence.

People and their relatives told us that staff were kind, caring and considerate. One person said, "They're excellent. When I've needed them they've been great." Another person we spoke with told us, "The two ladies that come to me are excellent. Very friendly and they're both dog lovers which is great because I've got two dogs." A relative we spoke with said, "They do exactly what they say they're going to do. They're always open and honest with me, and flexible and approachable always." Another relative spoke positively about the extra support their loved one had received from one of their care staff, and said "There was a carer who would always do extra things for me and ask how I am; they're a really lovely agency. At their heart, they care. That's really important."

The staff we spoke with demonstrated good knowledge of the people they supported. We saw that the

majority of the staff team had been with the agency for over two years, and were able to tell us about people and the support that they provided. One member of staff said, "I really love seeing my regular clients, and meeting the new ones. It goes beyond just going in and providing care for me, they're like part of my family now."

Requires Improvement

Is the service responsive?

Our findings

The assessments carried out prior to providing service to people failed to fully identify their needs or provide sufficient information for care plans to be developed. People and their relatives told us they knew there was a care plan in place and had been involved with the initial creation of their plan. One person said, "Yes there's a plan in the house that the carers can use." However people and their relatives were not always involved in changes to the plan or reviews to ensure that the information remained current. One relative said, "I think there's a care plan in here, it's largely a case of telling them if I needed anything changing but we don't do anything formal."

People's care plans lacked detail or accurate information relating to their care and were not subject to regular review. There was no background or social history to support staff to know and understand the person better. Each care plan contained a basic list of the tasks that care staff would follow when providing support, and some information in relation to continence, mobility, communication and diet. However this information was not person-centred and did not provide enough detail to enable staff to carry out tasks consistently and safely. There was no information regarding preferences as to who would deliver people's personal care, such as male or female members of staff. During the inspection we were told that one person's condition had changed significantly, and that they were displaying some behaviour that may have had a negative impact on others. However their care plans had not been updated to reflect this or to advise staff how to manage the person's changing needs. We were told about elements of people's care that were important to know to deliver support, but this information was not captured accurately in their records. For example we saw in daily notes for one person that they routinely refused their care. However this was not reflected in their care plan and there was no consistent guidance for staff to follow to develop a consistent approach to managing this. The issue had not been appropriately referred for professional input and there was no information available in relation to their capacity to refuse care or the impact upon them.

The plans we saw did not contain any evidence of reviews that involved people or their relatives. A relative told us, "[Relative] has a care plan; I was involved at the beginning but I haven't been involved in any reviews or anything." While there was evidence that people and their relatives were asked for their views as part of the quality monitoring process, there was no evidence of any changes made in response to concerns raised.

The insufficient care planning was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us they would complain to the manager if necessary and would feel comfortable doing so. One person said, "I've never needed to complain but I'd be happy to speak to the manager if I did." People told us their complaints were usually resolved, but we saw no evidence of how this was being documented. One relative told us, "I've spoken to the manager many times about timings and staff not turning up and it was resolved." People and their relatives had told us that they had discussed issues regarding call times with the manager, but we could find no evidence of these complaints having been recorded, investigated or responded to. We were provided with a complaints policy that was out of date and which contained contact details for the previous registered manager who had left two years prior

to our inspection. The name of another manager who had also since left was included in the policy as the first point of contact for people. The service had only documented one complaint since our last inspection, but the response to this failed to address the complainant's concerns adequately. The provider's response did not include any information regarding an investigation, nor any reassurance, apology or indication of how the complaint would be resolved. The response included extensive references to matters that bore no relation to the complaint. The investigation that had taken place included statements from staff that were inappropriate and should not therefore have been used as supporting evidence.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in post at the time of our inspection. The previous registered manager had cancelled their registration in August 2014 and while there was a manager of the service, no application to register them had been made. When we asked for the reason for the delay, the manager said, "The owner told me not to register as he is the registered manager here." However the owner had never applied to register as a manager and was not involved with the day to day running of the service. They had confused their role as nominated individual with that of a registered manager, which meant that the service had been operating for two years with no registered manager in place without good reason.

This was a breach of Regulation 5 of the Care Quality Commission (Registration) Regulations 2009.

The Care Quality Commission was not always notified of incidents. A recent safeguarding referral had been made to the local authority but we were not notified of this. The manager was not clear on exactly what was notifiable to us which meant that other incidents may not have been notified to us. When we asked for a full record of incidents and accidents since our last inspection this was not made available.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There were no systems in place to audit the service to identify improvements that needed to be made. The last business development plan had been written in 2013. There was no internal auditing of any systems to assess their effectiveness or compliance, and this meant that there was no overall governance of the service. People's care records, MAR charts and call times were returned to the office but there was no process for monitoring these or taking action to resolve any issues. Initially when we asked to look at people's care records these were only available until April 2016, and a care supervisor was asked to collect them from people's houses. This meant that the management staff had no way of checking the accuracy of this information. As a result issues relating to the delivery of people's care were not identified, and no action was taken to make improvements. A local authority monitoring visit in March 2016 had identified issues with quality assurance and auditing, but no action had been taken to rectify this. The lack of effective governance meant that the management staff had insufficient oversight of their care delivery and could not always guarantee the accuracy of records or resolve persistent issues. While the manager was open and honest about the issues in the service, action was not being taken to resolve them within acceptable timescales.

There were systems in place to gain people's feedback, although these were not always being acted upon. We saw that in each person's care plan there had been at least one 'spot check' to ask people and their relatives what they thought of the care being provided. However we saw that one person had raised an issue regarding call times and care staff arriving late, but there was no evidence that a response had been sent. Two of the people's files we saw contained no quality monitoring forms.

In March 2016 the service had carried out a quality assurance project where people and their relatives were provided with questionnaires in relation to reliability, the training of staff and whether carers were spending the right amount of time with people. The responses were largely positive with 90% of people saying they

would recommend the agency to others. A report had been put together which analysed the results of the survey and any action that would need to be taken in response. However in response to people's concerns about not being notified when carers were running late, the report said "this will be discussed in meetings and supervisions." However there had been no meeting since and most staff had not received a supervision either.

The provider's policies were almost all out of date and were not always being followed in practice. We looked at the provider's policies for medicines, recruitment, safeguarding and care planning and found that these had been devised using an external consultancy but bore little relation to what was actually being implemented in practice. The manager told us he was not aware of what was contained within these policies and therefore did not know whether they were being followed correctly. Failing to regularly review policies and develop systems for consistent care delivery meant that there was inadequate governance overall.

The lack of governance and quality assurance was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt able to contribute towards the development of the service and had their views listened to. One member of staff said, "I've had a lot of input into the service, they'll listen and take my ideas forward if they can." The staff we spoke with told us they had occasional meetings, but acknowledged that there had not been one for a while. One member of staff told us, "We do have meetings all the time to discuss what's going on, but we don't always write everything down or have the chance to get everybody together in one place." There had been two team meetings held since our last inspection, but none since October 2015. The issues discussed included call times, training and important issues concerning clients. While the minutes were detailed and thorough, the infrequency of formal meetings meant that the issues raised were not always being followed up.

People, their relatives and staff were all positive about the manager of the service. One person said, "I get on well with the manager and the deputy. The manager makes a point of calling in on me from time to time. When my [relative] goes away he'll call me every morning to check I've been okay during the night. They don't charge for that. That's really something." A relative told us, "The manager is a very caring and pleasant person." One member of staff said, "The manager and the deputy are really supportive, they've helped me out a lot." Another member of staff told us, "I love this company and I think the standard is really good. The managers are so supportive and approachable and they'll do anything to keep us all happy." During the inspection we found that the manager was open, honest and demonstrated positive values. He acknowledged the extent of the issues in the service and formed an action plan following our inspection to address the immediate concerns. He was able to tell us about the plans for the future and the improvements he wanted to make.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 5 Registration Regulations 2009 (Schedule 1) Registered manager condition The service had not had a registered manager in post since 2014, and no application had been made for the manager to register.

The enforcement action we took:

We issued a fixed penality notice to the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents We were not always informed of incidents which should have been notified to the Care Quality Commission.

The enforcement action we took:

We took urgent enforcement action on the 26 August 2016 to restrict new care packages being undertaken by the service.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was insufficient information contained within people's care plans.

The enforcement action we took:

We took urgent enforcement action on the 26 August 2016 to restrict new care packages being undertaken by the service.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were put at risk of not having their dignity upheld as insufficient staffing meant they did not always receive the personal care they needed on time.

The enforcement action we took:

We took urgent enforcement action on the 26 August 2016 to restrict new care packages being undertaken by the service.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not being managed correctly. The processes for risk management were inadequate.

The enforcement action we took:

We took urgent enforcement action on the 26 August 2016 to restrict new care packages being undertaken by the service.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not always being recorded or managed, and the response to complaints was inappropriate.

The enforcement action we took:

We took urgent enforcement action on the 26 August 2016 to restrict new care packages being undertaken by the service.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were inadequate quality monitoring systems in place to identify improvements that needed to made in the service.

The enforcement action we took:

We took urgent enforcement action on the 26 August 2016 to restrict new care packages being undertaken by the service.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff being deployed to meet people's individual needs. Staff did not receive regular supervision or updates to their training.

The enforcement action we took:

We took urgent enforcement action on the 26 August 2016 to restrict new care packages being undertaken by the service.