Elmar Home Care Limited

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Inspection report

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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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We inspected Elmar Home Care Limited on 16, 22, 23 and 24 August 2016. We usually give the provider 48 hours notice of our intention to inspect the service. This is in line with our current methodology for inspecting domiciliary care agencies to make sure the registered manager can be available. However, the registered manager had planned leave on the date we intended to inspect the office, so we rearranged the date which gave the provider five days notice.

The last inspection took place on 8 September 2014, when we found one regulatory breach which related to medicines.

Elmar Home Care Limited is a domiciliary care agency which provides care services to people in their own homes. When we visited the office the registered manager told us 88 people were receiving a personal care service. The agency provides a service to adults, older people, people living with dementia, people with physical disabilities, learning disabilities, sensory impairment and people with mental health needs.

There was a registered manager in post, who was also the nominated individual for the Company. 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.

Although people who used the service and relatives praised the kindness and caring attitude of the staff, they expressed concerns about the reliability of the service and the turnover of staff. They told us staff did not arrive at the times which had been agreed with the agency. We found agreed call times were recorded on the computerised system however there was no documented evidence to show when or who had been involved in discussing and agreeing these times. We saw issues around call times had been raised with the provider, sometimes repeatedly, but had not been resolved.

We found medicines were not managed safely as there were no records to show what medicines people were prescribed and administration records were incomplete. This meant we could not be assured people were receiving their medicines appropriately. These concerns had been identified at the previous inspection in September 2014.

The staff recruitment process was not robust as full checks had not been completed to make sure staff were suitable to work in the care service. Staff were not being provided with the necessary support and training to ensure they had the skills and knowledge to meet people's needs.

Although people told us they felt safe with the staff we found safeguarding incidents were not always recognised, dealt with or reported to the appropriate authorities. The registered manager told us all staff had received safeguarding training. However, two staff told us they had received no safeguarding training

and another said they had received safeguarding training five years ago.

Accidents and incidents were not always recorded correctly and there was a lack of evidence to show what action had been taken when these had occurred.

The registered manager confirmed they had received training in the Mental Capacity Act 2005 although our discussions with them showed they were not fully aware of their responsibilities under this legislation and they confirmed the staff had not received training in this subject.

Effective systems were in place which ensured people's nutritional and health care needs were being met.

People's care records did not always fully reflect their needs. Some people told us complaints they had raised had been resolved, whereas other said they had not. Although the registered manager told us they had dealt with any complaints raised, they acknowledged there were no records to evidence the actions they said they had taken.

We found a lack of strong leadership, ineffective quality assurance systems, weak communication and poor record keeping meant issues we found at this inspection had not been identified or resolved by the provider.

We found shortfalls in the care and service provided to people. We identified six breaches in regulations – regulation 18 (staffing), regulation 19 (recruitment), regulation 12 (safe care and treatment), regulation 13 (safeguarding), regulation 16 (complaints) and regulation 17 (good governance). The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded

The overall rating for this service is 'Inadequate' and the service is 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.

Medicines management was not safe as records did not show what medicines people were prescribed or if people were receiving these correctly.

Staff recruitment processes were not robust which meant staff's suitability to work in the care service had not been assured. Insufficient care staff were being deployed to ensure people's needs were met in a timely way.

Safeguarding incidents were not always recognised or reported.

Risks to people's health, safety and welfare were not properly assessed and mitigated.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received the training and support they required for their job role and to meet people's needs.

People's rights not were protected because the registered manager and staff did not understand their responsibilities under the Mental Capacity Act 2005.

People received support to ensure their healthcare and nutritional needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us generally staff were caring and kind, however two people raised concerns about staff practices and attitudes.

People were not always involved in making decisions about their care.

Is the service responsive?

Inadequate

The service was not responsive.

People's care needs were assessed however care plans did not always fully reflect people's needs.

Although there was a complaints procedure in place, we found complaints were not always dealt with appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

The systems for scheduling and monitoring care workers calls were not operating effectively, which resulted in inconsistencies in service provision.

A lack of robust quality assurance systems and poor record keeping meant issues were not identified or resolved. Leadership and management of the service needed to improve to ensure continuous improvement of the service.

Elmar Home 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.

The inspection was carried out on 16, 22, 23 and 24 August 2016. The inspection was announced. The provider was given five days' notice because the location provides a domiciliary care service and we needed to be sure that the registered manager was available. The inspection was carried out by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service. This included looking at information we had received about the service and statutory notifications the registered manager had sent us. We also contacted the local authority contracts and safeguarding teams.

We also asked the provider to complete 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. The registered provider returned the PIR and we took this into account when we made judgements in this report.

During the visit to the provider's office we looked at the care records of six people who used the service, six staff recruitment files, training records and other records relating to the day to day running of the service.

During the visit to the office we spoke with the office manager, two care co-ordinators, two care workers and the registered manager. The expert by experience carried out telephone interviews with 15 people who used the service and five relatives on 16 August 2016. The inspectors also spoke with five other care workers and a local authority quality officer on 23 and 24 August 2016

Inadequate

Is the service safe?

Our findings

At our last inspection in September 2014 we found a regulatory breach with regard to medicines as the individual medicines people had been prescribed had not been recorded. At this inspection we found the same concerns remained.

People we spoke with who were supported with their medicines felt these were managed safely and raised no concerns. The provider had a medication policy which provided guidance to staff on their roles and responsibilities. The provider told us all staff received timely medicines training. Staff we spoke with confirmed they had received training in medicines, although one staff member told us this had been 'years ago'

The registered manager told us they had amended the medicine administration records (MARs) and said these now listed the individual medicines people were prescribed rather than stating 'dosette box' as they had done at the previous inspection. However, when we spoke with the care co-ordinator they told us this had not happened.

We looked at people's care plans and found there was no information about the medicines people were taking. MARs we reviewed were poorly completed and it was not clear what medicines had been prescribed or when they had to be administered. For example, one person's MAR stated 'Dactort cream under arm'. There was no information on the MAR or in the care plan to show why this cream was being used, whether it was to be applied under one or both arms or how frequently. A further entry on the MAR stated 'dosette box'. Again there was no information on the MAR or in the care plan to show what medicines were present in the dosette box or how often these should be given. The MAR for July 2016 showed on some days the 'dosette box' had been administered twice a day, on other days three times a day and on one occasion four times a day. There were gaps on the MARs where there were no staff signatures to show medicines had been administered. This placed people at risk of harm as we could not be assured people were receiving their medicines as prescribed.

The registered manager told us the completed MARs were returned to the office on a monthly basis. However, the most recent MAR available in the office for one person was dated March 2016. There were no details in the care plan or on the MAR about what medicines this person was taking. We asked a care worker who provided support to this person, if they knew what medicines this person was taking and they told us they did not know. We saw there were 14 blank spaces on this MAR chart where staff had not signed to confirm medicines had been given. We checked the daily records and found 10 entries where staff had written medicines had been prompted. This left four occasions where we could not be assured this person had been given their medicines. We asked the registered manager if these calls had been made and they told us the staff member who would have made these calls had left. The registered manager agreed in the absence of documentation there was no assurance the calls had been made or that the person had received their medication on those four days. The registered manager said the medicines would not have been missed.

The registered manager told us the completed MARs were audited monthly by the care co-ordinator. The care co-ordinator told us they checked through the MARs and addressed any issues with staff. However, when we asked to see these audits they told us this was not recorded. This was a breach of the Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment files showed thorough checks were not always being completed to make sure staff were suitable to work in the care sector. We saw criminal record checks with the Disclosure and Barring Service (DBS) were completed and at least two written references were obtained. However, we found application forms were not always fully completed, there were no records of interviews and no discussions documented to show any gaps in employment had been explored. We found two references addressed to 'To whom it may concern' with no evidence to show these had been verified with the author. One of these references, for a care worker who started work in January 2016, was dated 2012. The second of these references was for a care worker who started work in May 2012 yet the reference was dated September 2013. The registered manager and office manager could offer no explanation about the latter. This showed us robust recruitment processes were not in place. This was a breach of the Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they felt safe with the staff who visited and this was the view of relatives too. Safeguarding procedures were in place. However, we found the registered manager lacked understanding of safeguarding and had not made appropriate referrals to the safeguarding team when concerns had been raised. The registered manager told us there had been no safeguarding incidents since the last inspection. However, one person told us of an incident that had occurred in February 2016. They said one of the care workers had hurt them 'physically' and described them as being a 'bit rough' when assisting them. They said their family had complained and care worker was removed. The person said someone from the office had visited them following the incident. The person said that this care worker had since come back. When we asked the registered manager if there had been any reported incidents of staff roughly handling people they said no.

Our discussions with a quality officer from the Local Authority showed a safeguarding referral had been made by a healthcare professional in August 2016 regarding the care provided to one person. The quality officer confirmed the registered manager had been made aware of the referral. The Care Quality Commission had not been notified of this referral as required.

The registered manager told us all staff received safeguarding training on induction through an external trainer. They said staff received safeguarding updates every three years which was provided by the care co-ordinator who had discussions with staff. Following the inspection the provider clarified that safeguarding refresher training was provided by a training consultant. This was not confirmed in our discussions with staff. For example, one staff member who had worked in the service for two years told us they had received no safeguarding training and were unable to describe the different types of abuse. Another staff member confirmed they had received safeguarding training when they started five years ago but had none since. A further staff member told us they had received no safeguarding training. This was a breach of the Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw general risk assessments in relation to people's homes were in place to ensure the safety of the individual and staff. This also included risks in relation to moving and handling. However, there was no evidence to show these had been reviewed or updated. For example, one person's risk assessments was dated June 2014 and another's January 2015.

We looked at accident and incidents reports which showed only two had been reported since the last

inspection, both of which related to staff members. One of these reports described an injury a staff member had sustained when a service user they were assisting fell in the shower. However, there was no accident report to show what had happened to the service user and whether they had sustained any injury. When we asked the registered manager about this they were not able to provide any further details. Complaint records we reviewed showed a person had fallen while staff had been present, the person had sustained a head injury and been admitted to hospital. There was no accident report for this incident and the Care Quality Commission had not been notified of this serious injury as required. We saw the next of kin had not been informed by the agency of the fall or that the person had been admitted to hospital and when we asked the registered manager about this they said it was not their responsibility to contact the next of kin and they would expect the hospital to do this. The registered manager told us they had investigated this incident however they were unable to locate any documentation to evidence this. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service and relatives expressed concerns about the turnover of staff and described the care staff as rushing from one visit to the next doing their best not to let people down. They were unhappy about the reliability of the service and said staff did not arrive at the times that had been agreed. For example, one person told us staff arrived at 10.00am to make their breakfast and visited again at 11.30am to make lunch. These were the comments people made, "Some girls are alright but no consistency of staff." "Some of the care workers do the necessary and are gone." "Not much time to listen short of staff." "Heaven know who is coming and when they are coming." "I'm on pins until they come." "They don't seem to have enough time." "Not coming as arranged." The registered manager provided us with survey results which showed the overall satisfaction with call times had fallen by 5% since 2015. We saw 83% of those surveyed were happy with their call times in 2015 compared to 78% in 2016. However, the surveys also contained some positive comments which showed some people were happy with the call times. The comments made were "Excellent, punctual and reliable service" and "Always punctual".

We asked care workers if they had allocated travelling time between calls, five staff told us they did not. When we spoke with the care co-ordinator they told us some calls were very close together so no travelling time was needed. The registered manager told us the computerised scheduling system would not allow them to add in travelling time. We looked at two of the scheduled 'rounds' and saw the time for staff leaving one call was often the same time they were expected to arrive at the next. For example, the finish time at one call was the same as the start time at another, however, the calls were 3.8 miles apart and the AA route planner calculated this journey would take 13 minutes. We made the same calculation for a number of other calls and found no allowance for travel had been made for journeys which took three to ten minutes by car. One relative we spoke with told us staff walked between calls.

The registered manager told us recruitment of care workers was ongoing. The care co-ordinator told us new staff were introduced to people before they started working with them. If care workers were delayed the procedure was they telephoned the office and one of the care co-ordinators would let people know they were going to be late. However, people and relatives we spoke with said new care workers were not always introduced and they were not always informed if staff were going to be late. This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there was a procedure in place for staff to follow if they were unable to gain access to a person's home. Two of the care workers told us they would shout through the letter box, check doors and windows to see if they could see the person, check with neighbours and contact the duty manager so they could try telephoning the person and their relatives. This showed us staff knew what to do if this situation arose.

We saw there was a policy in place in relation to infection prevention. However, we saw care workers

wearing rings with stones in and nail varnish, which the registered manager agreed was in contravention of that policy. We saw supplies of gloves and aprons were available in the office. One member of staff told us they kept supplies of these in their car to use in people's homes.

Requires Improvement

Is the service effective?

Our findings

We asked people using the service and relatives if they felt staff had the right skills and experience to provide them with care and support. One person said, "Mixed results, depends on the carer and level of training." One relative said, "Some [staff] are good and some are nowhere near." Another relative felt staff had not received the specialist training they required to meet their family member's needs. Two relatives said they felt more training would result in more competent and confident care staff.

The registered manager showed us the information file which they said was provided to each person when the service commenced. A document in this file stated 'all care staff have a vigorous induction procedure'. We asked to see the induction training records for recently employed staff. The registered manager told us new staff received the 'Employees Handbook' which contained information about policies and procedures and said new staff shadowed an experienced staff member. One of the care co-ordinators said they worked with new staff to provide them with training in practical moving and handling and delivering personal care and support. Staff were given a moving and handling workbook to complete and kept these for reference.

We found staff were not receiving formal training when they first started working for the service. For example, one care worker with no previous experience in care had not completed basic areas of training, such as food hygiene, safeguarding, infection control and first aid awareness, until after they had worked for the service for three months. Following the inspection the registered manager told us new staff were provided with training in moving and handling, infection control, food hygiene, catheter care and medication before 'shadowing' a more experienced staff member. They said this training involved two service users and was provided in their homes. However, there was no documentary evidence to show the content of this training, who had delivered it, when it occurred or the assessment of the staff member to confirm their knowledge, understanding and competence of the training they had received.

At a care plan review meeting in April 2016 a relative said they thought some care workers were 'frightened' when providing care and support. We asked the registered manager if staff supporting someone who may present with behaviour that challenged had received specific training and they told us they had not.

We saw staff were providing care and support for people who were living with dementia. We asked the registered manager if care workers had completed any dementia awareness training. The registered manager confirmed he and the co-ordinators had completed this training but said this had not been 'rolled out' to other staff.

We looked at the care records for one person who had a urinary catheter in place. We asked the registered manager what training staff had received and they told us training had been provided by the district nurses. However, there were no records to show who had completed this training and when it had been delivered. One member of staff told us they had completed training in relation to catheter care but this was when they worked for a different service.

There was no documentation to show exactly what new staff had been shown and no assessments of their

practice to confirm they were competent. We saw 'spot checks' were made to look at staff practice. However, we saw these were completed some months after new staff had started. For example, we saw one person had worked for six months before they received a 'spot check' and another staff member for three months.

We saw a relative had raised issues about one care worker's practice, so we looked in the care worker's file to see what action had been taken. There was no record of any discussions about the incident or about what action was taken to prevent a re-occurrence. We asked the registered manager about this and they told us they had spoken to the care worker in question but could not produce any evidence to support this.

Care workers we spoke with told us they felt supported by the care co-ordinators and the registered manager. We looked at the service's policies and procedures in relation to staff support. These stated supervisions should take place four times a year and staff should receive an annual appraisal. From talking with staff we found the supervisions were the 'spot checks' which were carried out on staff when they were working. One care worker 'spot checks' were recorded as done but they had not had one. We saw their name did not appear on the list as having received supervision.

In one care worker's file we saw their last annual appraisal had been completed in September 2013. We asked the registered manager about this and they told us they were behind with staff appraisals. They told us another care co-ordinator had been recruited which would enable another staff member to complete staff appraisals in a timely manner in future. We concluded staff were not provided with the necessary support and training to ensure they had the skills and knowledge to meet people's needs. This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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. In the case of Domiciliary Care applications must be made to the Court of Protection.

We asked the registered manager if any of the people using the service had a lasting power of attorney either for financial or health and care decisions. A lasting power of attorney (LPA) is a way of giving someone you trust the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future or no longer wish to make decisions for yourself. The registered manager confirmed there were some people who had a LPA however, when we asked to see this documentation they were unable to provide any evidence.

Although the registered manager confirmed they had received training in the Mental Capacity Act 2005 our discussions with them showed they were not fully aware of their responsibilities under this legislation. They told us none of the staff had completed Mental Capacity Act Training, which was confirmed in our discussions with staff. This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Most of the people we spoke with had support with their meals and all felt the care workers supported them well when they arrived. We asked care workers about people's nutritional needs. They told us they mostly prepared microwave meals or sandwiches and families usually did the shopping. One care worker told us people would tell them about their likes and dislikes.

The registered manager told us additional support had been provided recently to someone who was losing weight. A care worker told us the GP had been contacted and fortified drinks and puddings had been provided to try and improve the person's calorie intake. This showed us staff responded appropriately to people's changing nutritional needs.

When we spoke with staff they told us in an emergency they would call for an ambulance. One care worker gave us an example of when they had needed to call an ambulance because the person they had gone to support was experiencing breathing difficulties. They told us they stayed with the person until the ambulance arrived. A relative we spoke with praised the care worker for raising the alarm when her family member was found on the floor. They said the care worker acted swiftly and protected the person from harm.

Care workers said if there were other concerns about a person's health they would call the GP, district nurse or seek advice from one of the care co-ordinators. This showed us staff knew what actions to take to make sure people's healthcare needs were met. However, one relative told us their family member had had a chest infection a while ago and they were concerned they had not been contacted by Elmar Home Care Services and had instead been kept informed by Meals on Wheels and the day service the person attended. The relative said they had never been contacted by Elmar Home Care with regard to their family member's health.

Requires Improvement

Is the service caring?

Our findings

We asked people who used the service and their relatives how they felt about the service and how they would rate the quality of care. We received a mixed response and these were the comments made, "Not 100%." "Brilliant." "Elmar is the budget end of care." "Elmar is the best one (care agency) we've had." "Good and bad." "They certainly do a good job."

People and relatives spoke positively about the care staff who were described as 'fantastic' and a 'nice group of people'. One person said the staff were, "Adaptable girls who work around the needs of the people." Another person described staff as a 'right nice bunch'. A further person said, "They have a natter with [name of person] when I'm downstairs."

People told us staff were pleasant, kind and respectful to them. They said the care staff engaged in conversation with them while completing care tasks, although they were conscious of the time constraints. Staff we spoke with generally felt they had enough time to carry out the care people required. One staff member told us it was busy at weekends and the service was a 'bit short staffed at the moment'.

One person said there had been an incident when they had been left on the commode and said their dignity had been 'forgotten'. The person said they thought the care worker had not realised so the person had told them. Another person felt staff attitude could be improved and commented, "Some [staff] don't look at you."

Some people and relatives were compensating for the shortfalls in service provision. For example, one person's family told us they had taken over bathing due to the staff not having a rapport with the person. Another relative said they washed and dressed their family member if the staff were going to be late as the person was due at the day centre. Several people told us they were making their own breakfast if the staff were late.

We found there was a lack of information about people's lives, preferences or interests in the care records we reviewed. Only one of the people we spoke with and their family said they had been involved in reviews of their care plan. Some people told us the care staff who visited did not read their care plans. One person said, "I tell the carers go and read the care plan."

We saw care files and associated records were stored securely at the office base and systems were in place to dispose of confidential information. This meant people's personal information was held safely.

Inadequate

Is the service responsive?

Our findings

The care co-ordinator told us before a service started they visited the person and discussed their care needs with them and/or their relative. From these discussions call times were agreed and care plans and risk assessments were drawn up with the individual and their relative. This was confirmed in our discussions with the registered manager. Although we saw call times on the care worker schedules, there were no details in the care plans about the agreements which had been reached about the times of calls. The care co-ordinator told us this information was not recorded but said the preferred time was discussed between the co-ordinators and people were 'slotted in'. They said people were informed at the assessment that calls would be completed within a half hour window of their preferred time.

We saw care plans showed the support people required from staff at each call. The registered manager told us either they or the care co-ordinators carried out visits to review and update the care plans every four months or more frequently if required. However, we found shortfalls in the records we reviewed.

We saw in one person's care plan they needed support with their personal hygiene before they went to bed. When we looked at their daily records there was no evidence of this support being delivered. We asked one care worker who supported this person if they received this support and they said, "If they will let you." The care plan did not contain any guidance for staff about strategies to help support this person or the best approach to take. We saw this person's care plan had been reviewed twice once in March 2013 and again in April 2016. In both of these reviews concerns had been raised about the wrong continence product being used at night.

One person's care plan showed they needed support from staff to put on compression stockings. The provider's medicine policy stated staff would only assist in the application of compression hosiery when they had received appropriate training and been assessed as competent by the appropriate professional. We asked the registered manager if all the staff who visited this person had received this training and they said no. One of the care staff told us this person did not wear compression hosiery. This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the complaints log and saw three complaints had been recorded since the last inspection. Two of the complaints had been raised by the Local Authority and related to a missed call and concerns raised by a district nurse. The records showed how the registered manager had responded to both of the complaints. The third complaint was from a relative and raised concerns about an accident involving their family member and communication with the relative. We saw the written response the registered manager had made to this complaint.

However, the care records we reviewed showed other complaints had been raised by people and relatives. These were not reflected in the complaints log and there was no evidence to show what action had been taken to investigate or resolve these matters. For example, one person's care records stated the care co-ordinator had visited as several complaints had been raised by the relative about care staff, yet there were no records to show what these concerns were, how they had been investigated or what action had been

taken to resolve them.

We saw details of the complaints procedure was in the information pack which people were given when they started using the service. People and relatives we spoke with knew who to contact if they had a complaint. Some of those who had raised complaints told us the issues had been resolved, whereas others felt they had not been resolved. One relative said they planned to write to the agency about the care staff arriving too early to give their family member their evening meal. They said this had been an ongoing issue which had still not been resolved. We saw another person's care review in July 2016 raised concerns about staff arriving for the tea time call at 3pm when the call had been agreed for after 4pm. The records showed the next two days the tea calls were still being made before 4pm. The same issue was raised again on 4 August 2016 and records stated the tea call must not be before 4.30pm. The records showed the tea call the following day was at 3.45pm. The staff weekly newsletter for August 2016 stated, "[Name of person who used the service] under no circumstances must their tea call be before 4:15pm . Their [relative] has made a complaint as carers have been going at 3:20pm again this week." This showed us that complaints raised were not always dealt with appropriately or resolved. This was a breach of the Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service well-led?

Our findings

We received mixed feedback from people and relatives about the management of the service. Customer service on the phone was reported to be good, however people and relatives felt more effective communication from the management would assist in resolving many of the issues they had raised. The registered provider had also identified this as an area for improvement in the Provider Information Return (PIR) they had completed prior to the inspection.

We found a lack of strong leadership, effective quality assurance systems and poor record keeping contributed to many of the breaches we identified. The registered manager told us care plans and medicine administration records (MAR) were audited by senior staff when they were brought into the office from people's homes. They said MARs were reviewed monthly and all other care records were brought in every three to four months for review. However, there were no records to evidence this or to show the action taken when issues had been identified. There were no audits of staff recruitment processes and the issues we found had not been identified by the registered manager. Although the registered manager told us they had addressed areas of concern raised by people and relatives there was no documented evidence to confirm this or to show the action taken to prevent these situations recurring. Medicines were not managed safely and we identified the same issues around administration and recording as we had found at the previous inspection in September 2014. The registered manager told us an additional care co-cordinator had been appointed to enable the other care co-ordinator to have more time to work on the quality assurance systems.

We were aware a monitoring visit had been carried out in June 2016 by a quality officer from the local authority. The visit had identified shortfalls in medicines, care records, staff training, supervision and appraisal and guidance had been provided to assist the registered manager in making these improvements. Our inspection identified the same issues which showed these matters had not been addressed by the registered manager.

There was no electronic system in place to monitor care workers attendance at a call or the length of time they were there. We asked the registered manager how they knew all the scheduled calls had been attended and they told us care workers telephoned the office to confirm their scheduled round had been completed. One care worker we spoke with told us they did not do this. The registered manager told us there had been no missed calls since the last inspection, yet the complaint records showed there had been one in January 2016. A care worker also told us they had missed a tea call two or three months previously and had reported this to the office the following day.

The registered manager told us they sent out approximately 80 satisfaction surveys to people using the service in March 2016. Twenty had been returned and had been completed by people using the service or their relatives. We saw some positive comments had been made about the service such as, "Excellent service and personal cares, we look forward to their visits", "Very happy with service and staff who are always helpful and cheerful, well done!" and "Elmar in my opinion is an excellent company. Mum and I are more than satisfied with the care received." However, we noted twelve people had made negative comments

about the times of their calls. For example, "Would prefer the same time every day." "Night call varies." "Would like 9am call, sometimes they are over 30 minutes late." "Lunch, tea and bed calls variable." "Tea visits too early 3 and 4pm." "Would like to be up before 10:30am." "Rushing to next visit." "Too early or too late." These comments mirrored the feedback we received from the people and relatives we contacted.

The registered manager showed us a bar chart showing the comparison of results of the annual quality survey since 2013. We asked them if they had sent people using the service any information about the results of the survey. They told us where people had made individual comments they had been out to see them but had not provided them with any report about the findings or any actions they were going to take as a result.

We asked to see the minutes of any staff meetings which had been held. The registered manager told us they met with staff every Friday, when they came in to collect their rotas, but there were no minutes of their discussions. This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt communication as good, enjoyed working at the agency and felt supported in their roles. We saw weekly newsletters given to staff provided information about new people who had started using the service, people who were in hospital, on holiday or in respite care. There were also general reminders about signing medication records, laundry and delivery of personal care.