Health Care Resourcing Group Limited

CRG Homecare - Sleaford

Inspection report

Unit 4 Sleaford Business Centre
Station Road
Sleaford
Lincolnshire
NG34 7RG

Tel: 01205400127
Website: www.CRG.uk.com/homecare

Date of inspection visit:
27 September 2018
28 September 2018

Date of publication:
30 May 2019

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 27 and 28 September 2018 and was announced.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. They cover an area from Donington to Grantham in Lincolnshire. In addition, this service provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought or rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.
People using the service lived in an extra care housing scheme in Sleaford.

At the time of the inspection the provider was providing care for 97 people living in the community and 11 people in the extra care housing scheme.

It provides a service to older adults some of who may be living with dementia, younger disabled adults and people with mental health conditions. Not everyone using CRG Homecare- Sleaford received a regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

There was no registered manager for the service at the time of the 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.'

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."

We found that the provider was not meeting the regulations in regard of ensuring there were enough staff available. There were not enough staff to meet people's needs and consequently people's care was delivered late and at times calls were shortened to allow more people to receive care. At times this had impacted on people receiving their medicines in a timely fashion. This put pressure on the staff and consequently staff had not received regular support in the form of spot checks and supervisions.

The provider had also failed to meet the regulations in regarding to monitoring the quality of care. Systems to monitor the quality and safety of care provided were not effective and had not ensured that people's care had been delivered on time. In addition, we found that concerns round abuse had not been investigated in line with the provider's policies and people were unhappy with how the provider had responded when they raised concerns.

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

Staff were recruited safely and the provider completed the checks needed to ensure staff were safe to work with the people receiving the service. Staff training ensured that people received safe care and risks to people were identified in their care plans. However, care plans had not been updated on a regular basis in line with the provider's policies and charts to monitor people's food and fluid intakes had not been completed.

The provider had not ensured that people had received care from a small consistent group of staff. This meant that they had not been able to develop trust in the people providing their care.

The provider had started to gather the views of people suing the service. In addition, staff views had been gathered and staff had regular meetings to keep them up to date with changes.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People's privacy and dignity were respected by staff.

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 not enough staff to meet people's needs and care calls were not completed in a timely fashion.

Delayed calls impacted on people receiving their medicines in a timely fashion.

Safeguarding were investigated internally within the organisation.

Risks to people were identified and care was planned to keep them safe. Staff knew how to keep people safe from the risk of infection.

Is the service effective?

Requires Improvement

The service was not effective.

People were supported to access food and drink.

Staff received training to support them to provide safe care. However, supervisions had not been taking place due to the high workload.

People's needs were assessed before they started to use the service.

People were supported to access healthcare professionals when needed.

People's rights under the Mental Capacity Act 2005 were supported.

Is the service caring?

Requires Improvement

The service was not caring.

A lack of consistent care worker meant that people were not supported to develop a trusting relationship with care workers.

People's privacy and dignity were respected.

Is the service responsive?

Requires Improvement

The service was not responsive.

People's care plans had not been reviewed in line with the provider's policy and did not record activities people liked to engage with.

People's communication needs were identified.

While the provider had a system to manage complaints, people were not happy that complaints had been dealt with effectively.

Is the service well-led?

Inadequate

The service was not well led.

There was not a registered manager for the service.

The provider did not have effective systems in place to monitor the quality of care and to drive improvements.

CRG Homecare - Sleaford

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 on 27 and 28 September 2018 and was announced. We gave the service 48 hours' notice of the inspection visit. This was so they could arrange for us to speak to staff who were not based at the office. An inspector visited the office location on 27 September 2018 to see the manager and office staff; and to review care records and policies and procedures. An expert by experience spoke with people using the service via telephone on 27 and 28 September 2018. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

In preparation for our visit we reviewed information that we held about the service. This included the action plan completed by the provider following our last inspection. As well as notifications (events which happened in the home that the provider is required to tell us about) and information that had been sent to us by other agencies including the local authority contracting and safeguarding teams. We also used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with the two managers who were temporarily managing the service and the area manager for the service. We also spoke with two care workers and a member of the office staff. In addition, we spoke with 19 people who used the service and the relatives of two people who used the service.

We looked at a range of documents and written records including four people's care files and two staff recruitment records. We also looked at information relating to the administration of medicines and the auditing and monitoring of service provision.

Inadequate

Is the service safe?

Our findings

One of the interim managers for the service explained to us that they were currently having problems to recruit enough staff to care for people safely. They told us that the situation had reached a crisis point and they had had to review people's needs and decide who to prioritise care for. They had categorised people using the service into three groups. This identified those people it was most important to care for and who required medicines to be administered and they were given priority. At the other end of the scale were people who lived with someone else who would be able to provide the care needed. One relative told us, "Recently they have not been turning up at all. I think they rely on me being here to help my husband. But I can't be here all the time and I have my own appointments. One week we were on our way out at 1pm to the hospital appointment and they phoned to ask us if we still needed the morning visit, five hours after they were due to arrive."

The provider had arranged for some agency staff to cover their calls and office staff had also been completing care calls. However, we found that this had not improved the quality of care people received. At the time of the inspection the provider had 25 members of staff to cover the care needs of 108 people. One of the interim managers told us that they would need another 10 members of staff to ensure that they could meet people's care needs without the use of agency staff.

Some people told us they were happy with the care provided but most raised concerns about missed or late calls and care being rushed. One person told us, "[The regular care worker] was off and the [other care worker] didn't turn up and they didn't let me know. I had to phone them. It depends who is on whether you can get somebody on the phone at the weekends. It goes through to the Boston office in out of hours, but they are useless. They either always say the [care worker] will be there in 20 minutes even if they won't or she will say 'me not understand'. Also recently, about two weeks ago [the care workers] turned up four hours late for the morning visit. [The care worker] and another lady from the office turned up without uniform or ID. I had phoned numerous times and been told they were on their way. The next day they didn't turn up at all and the next day they were late again. Nine times out of ten the office staff don't know that [the care workers] haven't turned up or are off sick." Another person told us, "One [care worker] from Boston, did the visit in 10-15 minutes. It should be 45 minutes. I felt very rushed. She said she hadn't got time."

People were also concerned that calls were not evenly spaced through the day. For example, a morning call was not completed until 11am and then the lunch call was less than two hours later. This meant there was a risk of medicines being administered without the correct time between doses or people not being hungry when a meal was prepared for them. We spoke with one person who told us, "They can arrive anytime between 9am and 10.30am They don't normally let me know but would if they are terribly late. I have my tablets as soon as they come." They added, "I think they have been short of staff. I have to wait for them to arrive as they have to get me out of bed with the hoist." This person needed to have regular meals and medicine to manage a long term condition. When we spoke with the person it was 11:30am and they were still eating breakfast due to the late arrival of staff. This meant that they were late with their medicine which may impact on their health.

Another person told us, "I do have a regular [care worker] at the moment which is important as my legs have to be washed and bandaged carefully. About a month ago they missed a call. My regular [care worker] was on rest days and nobody turned up. I had to phone them, and they just said that somebody hadn't turned up for work. I just had to leave my legs that day. It's always more comfortable when they have been washed and dressed but I couldn't do it myself, so they were left that day."

We looked at the call rota for 17 to 23 September 2018 and could see that calls were not being scheduled at the time people had requested their calls. For example, we saw one person's planned morning call should have started at 9:35am. The Monday, Tuesday and Thursday morning calls had been completed two hours early. This meant that people's calls were unpredictable and not planned to meet their individual needs.

In addition, we saw that some call times had been cut short. For example, one person's bedtime calls had been completed in five minutes when the call was scheduled to last 20 minutes. In one case we saw that a 20 minute call had been completed in three minutes on 17 September, six minutes on 18 September and four minutes on 19 September. In addition, over the week, records showed that the length of time people should have received care was significantly reduced. For example, over the week one person who should have received three and a half hours of care, had only received two hours and 24 minutes. This was a reduction in their care time of over 30%. All these issues with calls meant that people could not rely on the service to provide them with the care needed to maintain their health and wellbeing.

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

We found that people were not always safeguarded from situations in which they may experience abuse. While some people told us they felt safe with the staff, others raised concerns about visits from staff that they did not know. One person told us, "With the more regular carer I feel reasonably safe but in the past I have not felt so safe. About a year ago a male carer appeared at the door with another man. He had stubble on his face and the top of his uniform was scruffy and undone and he had no name badge and nor did the other man. I had not seen either before. I asked to see their ID and one said he had forgotten it and the other that he had left it in the car. I wouldn't let them in so my wife had to help me. A week later the scruffy one turned up again and still no ID badge so I didn't let him in again. It made me feel quite vulnerable."

We found that people were not always safeguarded from situations in which they may experience abuse. While staff told us that they had received training in safeguarding people from harm it had not always been effective. We identified two issues where the provider's staff had not followed the correct process to safeguard people from harm. We raised these concerns with the managers at the service. After investigating they told us that these issues had not been raised with the local authority safeguarding team. They told us that they would review these concerns and the actions taken but were confident that people were safe as neither member of staff involved in the incidents still worked for the provider.

In addition, while some people told us they felt safe with the staff, others raised concerns about visits from staff that they did not know who did not present themselves in a professional manner and follow best practice guidance around identification. One person told us, "With the more regular carer I feel reasonably safe but in the past I have not felt so safe. About a year ago a male carer appeared at the door with another man… He had no name badge and nor did the other man. I had not seen either before. I asked to see their ID and one said he had forgotten it and the other that he had left it in the car. I wouldn't let them in so my wife had to help me. A week later… one turned up again and still no ID badge so I didn't let him in again. It made me feel quite vulnerable." This put the person at risk of abuse such as neglect as they had not received the care they needed from trained staff.

We found that risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. One person told us, "I do get some sore skin sometimes and [the care worker] makes sure she washes me and dries me exceptionally well. I sleep in a recliner chair as I can't get into the bed and they make sure they check my skin for any redness or soreness." Another person said, "I have had falls and have a rug by my fireplace. I know I should probably remove it. [The care workers] will notice if its curling up and straighten it for me."

Records contained information on areas of risk for people and the care and equipment needed to keep people safe. For example, when a person needed support to move around their home the care plan identified that they should be hoisted and that two members of staff were needed to do this safely. In addition, when people's needs had changed the provider had requested external advice to ensure people's safety. An example of this was a person being assessed by an occupational therapist when staff raised concerns that the equipment was no longer safe for the person. However, care plans had not been regularly reviewed and updated. Therefore, we could not be sure that the information they contained reflected people's current needs.

Some people had their medicine administered by the care workers with no problems. One relative told us, "They come to do the tablets mainly as he is better at taking them when somebody else comes in. The tablets are delivered each week and I have to collect the painkillers and inhalers. They put them in an eggcup and he takes them with no problems." This relative checked the Medicines Administration Record (MAR) and confirmed to us that it had all been completed.

However, other people raised concerns about the support they received with medicines and the late and missed calls had impacted on the administration of people's medicines. One person told us about the support they had received from a care worker who did not usually support them. They told us, "I take two tablets at teatime and four before bed normally but [the care worker] took the teatime and night tablets all out of the blister pack and put them all in one tub and she told me to take them all. I said, 'No' I wouldn't take them as I only take two at teatime. So that's what I did even though she tried to insist." Another person told us, "Yesterday evening was the first time nobody has turned up for the visit. They help me take my medication and I can't take it myself and so I just didn't have my medication last night. A third person commented, "They are supposed to prompt me with medication but if they are too early I have to remember to take my tablets before bedtime."

Staff told us and records showed that staff had completed training in the safe administration of medicines. We checked the MAR charts and saw that they had been completed to show which medicines people had taken. Care plans contained information on whose responsibility it was to obtain medicines for people.

Most of the people we spoke with were happy with the processes in place to keep them safe from the risk of infection. One relative told us, "They wear a uniform and a name badge. They always look fresh and clean and they wash their hands and wear gloves." While another person said, "They are good on washing their hands and wearing the gloves." Staff we spoke with confirmed that they were able to access protective equipment when needed. Records showed staff had received training in keeping people safe from the risk of infection.

We found that the provider had established suitable arrangements to enable lessons to be learned and improvements made if things went wrong. Records showed that seven incidents had been reported since May 2018. These had been investigated and action had been taken. Staff told us that learning from incidents was shared at staff meetings. However, staff and management had not always identified incidents. For example, we identified safeguarding concerns that had not been identified by the provider and so lessons

from these incidents had not been learnt or shared with the staff. This showed more improvements were needed to make the system fully effective.

The provider had systems in place to ensure they checked if people had the appropriate skills and qualifications to care for people before offering them employment at the home. For example, we saw people had completed application forms and the registered manager had completed structured interviews. Any gaps in people's employment history had been identified and investigated. The required checks had been completed to ensure that staff were safe to work with people who live at the home.

Requires Improvement

Is the service effective?

Our findings

Where people were at risk of being unable to maintain a healthy weight, care workers kept a record of their food and fluid intake. However, we saw that fluid charts had not been fully completed. For example, it would record that the person had drank some water but there was no record of how much. This meant it would not be possible to identify if the person had drunk enough to stay hydrated of if staff needed to encourage them to drink more.

Care plans contained information about people's nutritional needs. People told us that the care workers would offer them a choice of food. However, as care workers were not allowed to use cookers, food choices were limited to food that could be cooked in the microwave. One person told us, "I choose what I am going to eat. I have a lot of salads but they won't use my cooker and so I have to have reheated meals from the microwave. I tend to often clear up myself and can put things on my trolley to carry although they will put things in the dishwasher and will rinse the plates first as I do." Another person told us, "They heat me a dinner at lunch and then leave the pots and pans and they wash these when they come at teatime and clear the table."

The provider had a system of ongoing support and supervision in place for staff completing care. The field supervisor role was developed to spend 50% of their time completing spot checks and supervisions to ensure that staff were providing high quality care in line with best practice. However, a member of staff told us that due to staff shortages over the last few months they had not had time to complete the spot checks and supervisions as they had been too busy providing care to people. This meant that poor care practices would not be routinely identified.

Care workers told us and records showed that staff had received introductory training before they provided people with care. New staff were required to complete a three day induction, this covered areas such as supporting people to move safely and keeping people safe from the risk of infection. After completing the training new staff were required to complete shadowing shifts with experienced care workers and had their practical competency checks completed. Staff who were new to care also had to complete the Care Certificate within their first 12 weeks. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

The provider had a centralised training department which monitored the training needs of the staff. This identified when staff were due for training and staff would be notified when the training course was being held. The training matrix showed that the completion rate for training was 93%.

We found that some arrangements were in place to assess people's needs and choices so that care was provided to achieve effective outcomes. A member of staff told us that people who wanted to start using the service were booked in for an assessment. However, at times it was not always possible to get the assessment completed before they needed to provide care. Where this was an issue the provider would try to schedule a supervisor for the first visit so that they could assess the person while delivering the care. In addition, they would review the local authority paperwork which listed the person's care needs. Information

about the person's care needs could them be shared with care workers.

Staff told us that when they had started to work for the company they had been given a staff handbook. This outlined the provider's policies and ensure that staff had access to information regarding the national guidelines for providing safe care.

Suitable arrangements had been made to ensure that people received effective and coordinated care. Staff told us that they had a good relationship with the office staff and were able to raise concerns about people's wellbeing and they were confident the office staff would take appropriate action. In addition, care workers told us how they used the daily records and communication records in people's homes to leave messages for colleagues if they were concerned about people's health.

People told us they were confident that staff would seek healthcare advice for them if needed. For example, if there were any concerns over people's skin, people were confident staff would contact the district nurses.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

Care plans recorded people's ability to make decisions. Where needed guidance was recorded for staff about how to present information to people to support them to be able to make simple decisions. Care plans also identified where people had completed the required legal process to allow another person to make decisions on their behalf.

Staff we spoke with were knowledgeable about people's ability to make choices and that people were able to make unwise decisions if they had the capacity to do so. In addition, staff told us how communication was important when supporting people's decision making process. For example, they told us it was important to ensure information was given in a way they could understand. Staff were also aware that health concerns such as infection could affect people's ability to make a decision at a specific time and that they needed to be vigilant for sudden changes in people's ability.

Requires Improvement

Is the service caring?

Our findings

The staff managing the service told us that they liked to provide as much continuity as possible but that at times they needed to change staff to meet the needs of the service. However, we saw that the service had not provided compassionate care to people. Most people we spoke with told us that they had different care workers visiting them and they did not know who was going to turn up. One person told us, "I get different ones coming. At one time when it was going well it was the same people every day. Now I don't know who is coming or when. You can't put a time on it." In addition, people told us that care workers did not turn up at the specified time and communication from the office about changes in time were poor. A person said, "Sometimes they are quite late and they don't let me know. For me it's important they come at the recommended time as they have to help me with a lot."

We found that people had not been supported to express their views and not been actively involved in making decisions about their care and treatment as far as possible. People told us that the changes in visit times were to support the company and did not relate to the person's preferences about the time they received care. One person told us, "The carer who came in the morning this week I could set my clock by her 8am she would turn up but then suddenly its 9am. They have fitted somebody else in before me on her rota and without telling me or any discussion at all. When I phoned I was told the person was more of a priority then me. So as now they come at 7.30am in the evening I spend more time in bed and that's just to suit the organisation not me."

People told us that they had not been offered the choice of whether they received care from a male or female care worker. Several ladies told us that they received care from a male care worker. Some of the ladies told us that they were not happy about receiving care for a male care worker. The staff managing the service told us that the preferred gender of care worker was included in a new assessment they were about to implement.

Where people received support from regular care workers they told us that they had a good relationship with the care worker. One person told us, "It's more or less the same people but they are all perfect. They help me out of bed and into my chair for a wash- they always wash me properly- they are marvellous. They always get me a cup of tea and have a chat." Another person told us, "There is one who comes more often and she is kind and will offer to do anything. There are several Polish and Czech girls and they offer to shower him, but he doesn't want it at the moment. There are no language problems with them. They stay and have a little chat and a bit of banter which he likes." However, people who did not have a regular team of care workers were less complimentary about their relationship with the staff.

People's privacy, dignity and independence were respected and promoted. Staff told us they had received training in how to maintain people's privacy while providing care. People told us that staff respected their privacy. One person said, "They are respectful. For example, they place a towel across my bottom half as they wash me. They give me their full attention. They ask my husband how he is too." In addition, staff did not gossip about people they provided care for. One Person told us, "They never talk about others. I did ask them about a friend of mine who I know they visit in the village. They said they couldn't say anything."

Another person said, "She never talks about other people. She may say she is late because one of her patients is poorly but never mentions names."

Suitable arrangements had been made to ensure that private information was kept confidential. For example, staff rotas did not have a house number or key safe number printed on. We saw that written records which contained private information were stored securely when not in use. In addition, computer records were password protected so that they could only be accessed by authorised members of staff.

Requires Improvement

Is the service responsive?

Our findings

People told us that they had received an assessment before or just after they had started to receive care. This assessment was used to develop a care plan for people. One person told us, "One of the managers/supervisors came out initially and listened to exactly what I needed and they do come out occasionally as a carer when they are short of staff." Records showed people had signed their initial care plan to say they agreed with the content.

In addition, staff told us that the provider's policy was that care plans should be checked every three months to ensure they still reflected people's needs or when people's needs changed. However, records showed that reviews had not taken place in a timely manner. A person using the service told us "Nobody has been out to check me or go through the care plan. Maybe they did in the early days, but it must be more than six months ago. I think they did come out to check the plan in the past." Another person told us, "Somebody came out to do the paperwork when I started with them. She was good and seemed to be listening and asking me questions. My only contact is with the carer. I never look in the folder or at the care plan. She fills in the orange one every day." Another person told us that their care plan had not been updated following a diagnosis of a long term condition. We saw that one care plan which had been completed in August 2017 had a note which said it needed updating. However, this had not been completed. The staff also had a spreadsheet to track when reviews were due and we could see that the majority of people's care plans were past their review date. Therefore, we could not be sure that records contained accurate information where people's needs had changed. This could place people's health and safety at risk.

The provider had assessed people's communication needs and how they would prefer information to be presented to them. If needed, the staff were able to access key pieces of information such as the service user guide and complaints information in different formats such as large print or in a different language.

The care plans we viewed contained person centred information to support the care staff to tailor the care to people's individual needs and to encourage them to offer people choices. For example, we noted that one person liked all the internal doors in their home left open. In addition, there was a communication page in the care plan for care workers to pass along important information to colleagues.

Care plans did not record any activities that the person liked to take part in. While staff did not support activities the lack of information meant that they could not ensure that people had everything within reach to be comfortable and entertained between visits.

Suitable provision had been made so that people could be supported at the end of their life to have a comfortable, dignified and pain-free death. While the service had no one at the end of life at present. The staff managing the service said that they would provide palliative care for people using the service.

People told us that while they knew how to make complaints and had made some, there had been no improvements in the care they received. One person told us, "A young lady came out to see us and when she came here she made all the right noises and we were comfortable in her company and gave us light at the

end of the tunnel, but nothing has come of it and she didn't follow through." Another person said, "I have complained many times but nothing changes and they don't even phone back. I have repeatedly told them I don't want male carers but they have sent male carers several times. I turned him away as I didn't feel comfortable with him putting me to bed. When I phoned to complain I was told that I can't have a carer then if I didn't want him and I would not get care and so I had to manage myself." A third person said, "I did phone the office to complain- I tried to phone the Sleaford office but there was no answer so I phoned Boston and they basically said, 'Who are you?' I then filled out the online form on their website and had only an automated acknowledgement email but have had no other response from the organisation. They must have received it as the carer then said to me 'I hear you have complained about me'."

Records showed that the provider had received 18 complaints since March 2018. We saw that these complaints had been investigated and records showed that the provider had identified action to help reduce the risk of issues reoccurring. However, considering the feedback we had received from people using the service we could not be sure that all complaints had been identified and actioned. The staff who were managing the service told us how the provider was investing in a new system to manage complaints more effectively.

Inadequate

Is the service well-led?

Our findings

People told us they were not happy with the quality of care they received and did not consider the service to be well led. One person told us, "This is the worst care agency I have ever had. On a regular basis, one to two days a week, they are not turning up at all. It's usually the weekend or Monday. This has gone on for the last at least three months. They bring a woman in from another company to visit me and I don't think she works those three days. You can't plan anything, we're on tenterhooks not knowing if they are going to turn up. They never have the time to read the notes in the book and never bother to read them. I do feel frustrated. I do have some cognitive problems and I get tired so it's hard for me to deal with these issues. If they don't turn up by 9am we send them away as my wife has by then already helped me." Another person told us, "I think most of the carers enjoy their job but they are constantly hassled and their rotas being changed and they have to cover large distances. They are contacted even on their days off. The carers do tell us a lot about the problems with the organisation."

There was no registered manager for the service. The provider is required to have a registered manager as a condition of their registration. 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. Our records showed that the provider had been without a registered manager from 1 June 2018.

There were two interim managers managing both this service and another service for the provider. However, this was a temporary measure as both had other positions in the provider's company waiting for them and so were only able to support the service for a short time. Following the inspection, the provider told us they had recruited an experienced manager for the service and they would be requiring them to become registered.

We saw that systems to monitor the quality and safety of the service were inadequate. Some auditing of medication administration and daily records had been completed on a risk based rational. Staff were unable to provide us with complete information about how many calls needed to be completed each week and how many had been completed within the last week. This was because some people were not recorded on the system as receiving care from this service.

In addition, where calls were completed they were not always recorded on the system as they had been completed by agency staff. When we discussed this with the staff managing the service they told us that agency staff had not been provided with the equipment needed to log their time of arrival and time of departure on the system as the provider's staff did. In addition, some office staff had been completing calls and they too did not have the equipment to log their calls onto the system. This meant that the provider was unable to provide us with reassurance that all the calls had been completed.

Furthermore, there had been no auditing of the calls which had been recorded as completed. This meant the provider had not tracked how many calls had been completed late and how many calls had been cut

short to enable staff to care for more people. The staff managing the service told us that this had been identified as a concern and that a new job role had been created to monitor and manage concerns around call times and call length.

Furthermore, we found the systems in place to monitor the care plan reviews were not up to date. The report which identified when people's care plans were due for review did not include all the people who were receiving care from the service. This lack of reliable data meant that the systems to manage the service did not support the safe, effective delivery of care.

Systems for managing complaints had not been effectively managed. As highlighted in safe and responsive, possible safeguarding's, had not been investigated in line with the provider's policies. In addition, while the provider had a system to manage complaints people told us that the provider did not respond when they raised concerns and no action was taken to improve the issue they were complaining about.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

Staff we spoke with were dedicated to their roles and wanted to provide high quality care for people. One member of staff told us, "I love my job and I love the clients and all the staff are passionate about the people we support." However, they identified that they were struggling to meet people's needs due to staff shortages and poor scheduling.

Nobody knew the name of a manager and few people had much contact with the senior staff or office. Most people reported that it was very difficult to get through to anybody at the Sleaford office and that when they contacted the Boston office they were met with disinterest and lack of knowledge. One person told us, "We have the Sleaford office number but sometimes they don't answer at all. If we phone the Boston office they say we should phone Sleaford. You never know who is in charge of the office- they haven't got a clue. My communication with the office is non-existent." Another person said, "Sometimes it's hard to get hold of the people in the office. I occasionally phone with a question such as if they are running a bit late and some are better at answering my questions than others." A third person commented, "I quite often can't get a reply from Sleaford. I think they are short staffed and all out doing the caring."

The staff managing the service told us that they had just sent out a questionnaire to gather the views of people receiving care. Some people told us that they had been contacted for their views on the care they received. For example, one person told us, "They have sent me a questionnaire but nothing was needed as I am happy with the service." In addition, a staff survey had also been completed.

Team meetings were in place to help care staff to be clear about their responsibilities. One member of staff told us that they had recently had a team meeting once a month, they told us, "We will discuss concerns on a client and discuss new clients. And any likes and dislikes and learning case studies." Minutes from the last meeting showed they had discussed issues such as calls being ended before all care had been given and tasks such as tidying up or making sure person had a drink or snack available had not been completed, although all personal care and medicines had been given.

The provider had recently had a meeting with the local council who commissioned care for people using the service. Areas of concern had been identified and the provider had an action plan in place to improve the quality of care provided for people. For example, they were looking to use incentives for staff to remember to log each call on the system and rewards schemes to recognise the hard work of the staff. In addition, they were looking at setting up regular rounds for staff to increase the consistency of care provided.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were enough staff to meet people's needs.

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 17 HSCA RA Regulations 2014 Good governance The provider had not ensured there were effective systems in place to monitor the quality of care provided and to drive improvements.

The enforcement action we took:

We imposed a condition to require the provider to submit management information to us.