Mr Roger Henry Pickford

Evoke Home Care

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection started on 15 February 2018 and was unannounced. The service was previously inspected in September 2017 and was rated Inadequate. This was because there were eight breaches of regulations. Major concerns were around the safety of the service and the management and leadership arrangements. The service was placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

At the time of this inspection the service was providing support to 27 people who lived in their own homes, of these 23 people were receiving the regulated activity of personal care. Another four people received domestic assistance or companionship and this part of the service does not come within the remit of the registration. The service was provided to people who lived within the Bristol area. The service employed 14 care staff and three office staff.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009 (part 4). You can see what action we told the provider to take at the back of the full version of the report.

There were insufficient care staff to meet the number of people being supported by the service at the time of the inspection. The service were using agency staff to fill the shortfall but people were not happy with the number of their care calls covered by unfamiliar staff. People did not always know which member of staff was planned to cover their care calls and they did not like this.

The service continued to not follow safe recruitment procedure which meant the potential for employing unsuitable staff placed people using the service at risk. The service had failed to act on the findings from the last inspection.

People were not receiving a person-centred service. The service provided was based upon the resources the service had to offer and did not always take account of agreed timings and length of care calls. Whilst there had been some improvement in late, missed and shortened calls people were still not satisfied with the service they were provided. Relatives described the service as unreliable and a great cause of stress for them. The service had failed to act on the findings from the last inspection.

The training arrangements for new care staff and for the existing staff team did not ensure they had the

necessary skills to provide a good service. We found that the training for new staff being inducted had been signed off in one or two days and a check on learning had not been carried out to check their learning. Sufficient improvements had not been made to ensure existing staff we all up to date with their mandatory training. The service had failed to act on the findings from the last inspection.

The registered provider did not have a system in place to handle and act upon any complaints made about the service. People and their relatives told us about concerns and complaints they had raised but these were not logged. There was no record of any actions taken. The service had failed to act on the findings from the last inspection.

The registered provider and all other personnel brought in to make improvements to the service did not have sufficient insight to the legislative requirements in delivering a care service. The registered provider was unaware of the need to display their quality rating poster so prospective service users or staff could judge whether they wanted to use the service. The registered provider had failed to keep their statement of purpose up to date. The statement of purpose sets out the aims and objectives of the service so that people know what to expect.

The registered provider did not quality assurance systems in place to check on the quality and safety of the service. This meant the registered provider was not aware of how the service was complying with the Health and Social Care Act 2008 and could not make improvements. The service had failed to act on the findings from the last inspection.

All care staff were expected to complete safeguarding adults training and records showed all staff were up to date with this training. The service was still the subject of on-going organisational safeguarding monitoring but no further concerns had been raised since the last inspection. The acting manager and senior staff were still waiting to attend local authority safeguarding training.

As part of the care planning process a range of risk assessments were undertaken to ensure people being supported and care staff were not harmed. All work activity tasks were risk assessed including moving and handling tasks.

Where people needed support with their medicines, a plan of care detailing the exact help they needed was in place. Care staff were supplied with personal protective equipment to enable them to prevent any infection being spread. Where people needed support with eating and drinking, or for contacting health care professionals, they were supported by the care staff. The level of support the person required was detailed in their care plan.

There was a lack of consistency in the effectiveness of the care and support provided because people received assistance from many different staff. People were not provided with a person centred service that met their assessed and identified care and support needs. It was the practice they were provided with whatever resources could be arranged on a given day. The service provided was not effective and people's relatives had to pick up the shortfall.

Each person had a well written plan of care written, however, the service they received did not match these care plans. The plans were detailed and provided a good pen picture of the person and their family and working life but the way the service was arranged did not enable the care staff to deliver that care and support.

Care staff asked people to give verbal consent before they offered any assistance. They only received

minimal training in respect of the Mental Capacity Act 2005.

Full information about CQC's regulatory response to any concerns found during inspection is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The recruitment of new staff did not follow safe practice meaning that unsuitable staff could be employed. This placed people at risk of harm.

The service was using agency staff as they had insufficient care staff to cover all care calls. New packages of care were not being taken on. People were not satisfied because they did not know who was going to support them with their care.

Care staff had a good understanding of safeguarding issues and knew to report concerns they had about people's welfare and safety. Any risks to people or the care staff were assessed and plans put in place to reduce or eliminate the risk.

Where people needed assistance with their medicines this was recorded in the care plan. Care staff received training to ensure they were competent to administer medicines safely.

Is the service effective?

Inadequate

The service continues to not be effective.

People's care and support needs were assessed but the service they were provided with was not always effective or organised in a person centred way.

Staff training, supervision and support needed to be improved to enable them to deliver a better service. The organisation of the service compromised their ability to do their jobs effectively.

Staff gained people's consent before providing a service but they would benefit from greater understanding of the Mental Capacity Act 2005 (MCA).

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not satisfied with the service they received. They

were not always well supported or cared for nicely

Care staff were not always able to support people in the way they wanted because of constraints on their time.

Is the service responsive?

Requires Improvement

The service continues to be not fully responsive.

People were not listened to and their views and opinions were not considered as being important. People were given a copy of the complaints procedure but any complaints were not handled correctly.

People received a service that did not always meet their needs. Reviews of care plans and people's needs were not consistently carried out.

Is the service well-led?

Inadequate

The service was not well-led.

The registered provider lacked the insight to provide good leadership and management of the service. Other family members who assisted the registered provider did not have a health or social care background and were unaware of the legislation. There was a new office staffing structure in place but this was chaotic.

The registered provider did not have quality assurance systems in place. The quality, safety and compliance with the Health and Social Care Act 2008 was not measured. No actions were taken to deal with the shortfalls in service provision.

Evoke Home Care

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

The inspection team consisted of two adult social care inspectors.

Prior to the inspection we looked at information we had received about the service since the last inspection. This included information passed to us by the local authority. It also included information from people who were using the service or their family representative and weekly information we had been asking the registered provider to submit. We were doing this because we wanted to monitor how the service was performing. No notifications had been submitted to CQC since the last inspection. A notification is information about important events which the service is required to send us by law. Five new safeguarding concerns had been reported to the local authority since September 2017.

During the inspection we spoke with the registered provider and other members of his family who have been assisting him since the last inspection. We spent time with the acting manager the care coordinator and the office manager. We spoke with eight care staff, 11 people who received a service in their own home and seven relatives. We looked at 21 people's care records, six staff recruitment files and training records, key policies and procedures and other records relating to the management of the service.

We received feedback from three social care professionals during the inspection period. We asked them how confident they were in the service. They told us what their views where of the service since the last inspection and we have included their comments in the main body of the report.

Inadequate

Is the service safe?

Our findings

When we inspected this service in September 2017 it was not safe and we rated this area as Inadequate. This was because care calls were being missed and people were left without support for meals and medicines (breach of regulation 12 of the Health and Social Care Act 2008 (HSCA 2008)). We also found that the recruitment procedures were unsafe and the risks of employing unsuitable staff had not been mitigated (breach of regulation 19 HSCA 2008). At that time there were insufficient numbers of care staff to cover all the care calls the service had agreed to cover (breach of regulation 18 HSCA 2008).

Since the last inspection the service had reduced the number of people they provided support to. They no longer provide a package of care to any person who required two care staff at the same time to deliver their care. They were not providing a care service to people who had complex care needs. However, there had also been a high number of staff who had left Evoke Home Care. The service was using agency staff to cover the shortfalls they still had. For consistency, the care agency they used were supplying three regular care staff. People we spoke with said many of their calls were provided by the agency staff. The office staff supplied us with carer visits summary documents, for the previous five weeks. In the week commencing 15 January 2018 only 6% of care hours delivered were by agency staff. Weeks commencing 22 January, 29 January and 5 February 2018, this percentage had increased to 34%, 35% and 32% respectively. Agency use during the week the inspection started had increased to 46% due to holidays and sickness.

People said, "I would like to know who is coming to me. The schedule often just says Carer 1 or Carer 2", "I never know who is coming through the door. I am 99 and I would prefer to know", "Evoke do not have enough staff and I think they are struggling to cope" and "I know they don't have many staff now and I worry that no-one will be coming to me. I worry I will get in to difficulty and I don't feel safe".

Since 23 November 2017 we have asked the registered provider to submit weekly statistics showing how many missed, shortened or late calls had occurred. Over the weeks, the prevalence of these had reduced significantly, showing an improvement in service delivery. However, the service needs to be able to sustain improvement. One week after completing the inspection, we were notified three planned care calls had not happened and failings in communication had contributed to this.

The service did not have strategies in place to cover staff absences and people were often not informed about staff changes and changes in the timing of care calls. The registered provider said they planned to recruit additional staff in order to be able to grow the business and reduce their reliance upon agency staff.

The service continued to follow unsafe recruitment procedures. Of the six staff files we looked at, four of them did not have written references. We discussed this with the registered provider who did not know where to locate these. The acting manager was also unable to find these documents. For one new member of staff, the name given for their reference was a parent and this was not appropriate. One staff recruitment file that we had checked in September 2017 still had no references on file. The registered provider had no satisfactory explanation about this.

This is evidence of a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered providers training programme included safeguarding adults training. The training matrix showed the dates that all staff had last completed this training. All the staff we spoke with knew what was meant by safeguarding people and would report any concerns they had about a person's safety to the office. Some knew they could report concerns directly to the local authority, the police and the Care Quality Commission. The service were still under organisational safeguarding monitoring however there had been no further safeguarding concerns raised. At the last inspection in September 2017 we had recommended the registered provider, the newly appointed team leaders and the care coordinator attend formal advanced safeguarding training with the local authority. The acting manager said they were still waiting to be allocated a date for this training. The training matrix showed that the new coordinator and one other person, brought in to support the registered provider had completed some safeguarding training.

Care staff received moving and handling training from an external trainer. The service did not have a key mover, a member of staff who had completed additional moving and handling training and were taught how to instruct staff on best safe practice. This shortfall had the potential to mean that if a person's mobility changed, the care staff would not have the ability to get prompt advice on how they should assist.

This is what we wrote in the last inspection report regarding the management of risk. There has been no change in our findings on this inspection. Risk assessments of people's homes were completed in order to ensure the person's home was a safe place for the person and for care staff to work in. All work activity tasks were risk assessed including moving and handling tasks. There was an expectation that care staff would report any health and safety concerns they had to the office. A fire risk assessment was completed as well as the likelihood of falls and the person's susceptibility to pressure damage to their skin. Moving and handling risk assessments were completed where people needed to be assisted by the care staff and a support plan detailed the equipment to be used and the number of staff required. Care staff were provided with information in the assessments and care plans to ensure they carried out moving and handling tasks safely.

This is what we wrote in the last inspection report regarding the management of people's medicines. There has been no change in our findings on this inspection. People were encouraged to remain responsible for their own medicines where possible. Where people needed support with their medicines the assessment of their needs would identify the specific assistance they required. The medicine management policy stated that care staff would receive training to ensure they administered medicines safely. Their competency to continue administering medicines safely was rechecked regularly and we saw the records of these checks. People gave written consent to be supported with their medicines as part of their overall agreement to their care plan.

The support people needed with their medicines was recorded in their care plan. The care plans stated whether the person required level one support (general assistance and prompting), level two (assistance and administration) and level three (specialised support). No-one was receiving level three support at the time of the inspection. Care staff had to complete a medicine chart after medicines had been given or creams had been applied. Where people needed medicines on an as and when required basis, there were clear protocols in place with detailed instructions for the staff to follow.

We did not have any concerns regarding how the service managed the control and prevention of infection however infection control training did not appear on the registered providers training programme. Care staff were provided with supplies of personal protective equipment (gloves and aprons) and confirmed these were always available.

Inadequate

Is the service effective?

Our findings

When we inspected this service in September 2017 it was not effective and we rated this area as Requires Improvement. This was because people were not being provided with a person centred service and their care calls were being cut short. The care staff were unable to do everything they were expected to do because care calls were being rushed (breach of regulation 9 of the Health and Social Care Act 2008). The service was also in breach of regulation 18 because staff training was not good enough.

People's needs were assessed and a plan of care devised stating how Evoke Home Care was going to meet those needs. But there was a lack of consistency in the effectiveness of the care and support provided.

Since November 2017, we have asked the service to submit weekly statistics at the end of the week. We asked them to tell us about missed care calls, shortened care calls and late care calls. Over the weeks there has been an improving picture but there were some minor trends where there had been increased staff sickness and leave. This had affected service provision. People we spoke with during the inspection told us there was still a problem with shortened care calls and they received a service that was less than they expected. Staff also told us they were still being asked to fit in extra care calls. Two people gave us specific times when their care calls had been cut. One person was told they could not have their three hour call on 16 February and was only provided with 1.5 hours. The electronic records confirmed this. The other person told us instead of a 1.5 hour call the day before they only received only one hour of support. They said, "They are constantly cutting calls". Neither of these two people had their care package commissioned by Bristol City Council therefore the electronic call monitoring was not used.

People were not provided with a person centred service that met their assessed and identified care and support needs. It was the practice they were provided with whatever resources could be arranged on a given day. The service provided was not effective and people's relatives had to pick up the shortfall.

The family of one person told us meal preparation was one of the tasks the care staff had to complete. When a Sunday lunchtime call had been missed, the person had microwaved their own meal. This person was living with dementia and was not safe to do this. Another person said the care staff just made her the same sandwiches everyday for her tea and she was bored with them. She said she had asked them to do something else but they said they did not have time. The family of a third person said the care staff did not ensure sufficient drinks were left in between care calls.

This is evidence of a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The induction training programme for new recruits was inadequate. Three new staff had been recruited since the last inspection. Their training files contained many certificates regarding training completed. Whilst the training modules were in line with the requirements of the Care Certificate, the way the programme was delivered and completed was inadequate. All training modules were recorded as having been completed on one day. The training was delivered by video then there was a worksheet to complete.

The purpose of these was to check the staff members understanding. The work sheets had not been checked, signed or dated therefore the provider could not be certain the new staff understood the training and what they were supposed to do. Some training was recorded as having been completed, there was a certificate but no worksheet. At the last inspection in September 2017 we recommended that the registered provider look at best practice for induction training and familiarise themselves with the Care Certificate. This advice had not been acted upon.

For the rest of the staff team there was a programme of mandatory training. We asked care staff about their views regarding training and received mixed views. One staff member said, "We just watch videos". Another said their training was all up together but they were due to redo their moving and handling training. A third staff member told us they had done training two weeks previously but they could not remember what the subject of the training was. We asked this staff member if a senior member of staff had ever watched them working and they confirmed, "Yes, about three years ago".

A training record was kept for each staff member and the acting manager was in the process of putting together a training matrix. We were advised this was not up to date and was work in progress. From the records that were shared with us it was not possible to evidence that all staff had received their mandatory training. The acting manager told us Mental Capacity Act 2005 (MCA) training had been completed by herself and two other senior staff. All other staff would do mental health training and this included the principles of the MCA.

A programme of staff supervision had been implemented at the beginning of 2018 and a senior member of staff was starting to do spot checks on the care staff work performance. At the last inspection in September 2017, we were told staff meetings were planned week commencing 25 September. There were no records of this or recollection that these had happened. Between 1-15 December 2017, the registered provider had individual meetings with seven members of staff. It was recorded two staff had expressed concerns regarding the out-of-hours support. Others had reported difficulties with communication between the office and care staff, the work rotas and being bullied to do extra calls. There was no record of any action taken as a result of this staff feedback.

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

Care staff asked people to give verbal consent before they started to provide any assistance and asked them what they wanted done during that visit. People we spoke with said regular care staff just got on with what they knew they had to do but new care staff would ask them what they wanted done. The training matrix the acting manager provided showed that only three staff members had completed Mental Capacity Act 2005 (MCA) training in 2015 or 2016. One was the acting manager. The other two were care staff . The MCA sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected. The acting manager said the MCA was covered in the mental health training but six staff members did not appear to have completed the mental health training.

Requires Improvement

Is the service caring?

Our findings

When we inspected this service in September 2017, it was not always caring. This was because people and their relatives said the office staff could be abrupt and not helpful, the care staff moaned and groaned to them about their work and all the good staff had already left the service.

People still felt they were not well supported or cared for nicely. They said, "I am fed up with Evoke. I am having loads of different care staff visit me", "My family are looking for an alternative caring company as we are fed up", "Messages do not get passed on and then they tell me it is my own fault if they cannot provide a call" and "I have to insist that care staff come and see me when they ring and say they cannot send anyone". Relatives made the following comments, "The manager argues with me and can be very rude", "That company (Evoke) have made a really stressful time even worse. The impact on the family has been tremendous" and "We are continually being asked to cover Mum's care calls. There is an expectation that the family will cover".

The quality assurance survey that had been completed in July 2017, evidenced there was a great deal of dissatisfaction expressed by the people using the service. In September 2017, we found the registered provider had taken no action to ensure that every person supported by the service was always treated with respect and dignity. No new survey had been completed.

The care staff we spoke with were trying to provide a decent service to people but felt the organisation of the work rotas was "shambolic". They said there were constant last minute changes and they were frequently contacted to fit in extra calls. This compromised their ability to support people in the way that was planned. Several of them said they only stayed with Evoke Home Care because of the regular people they supported and not out of loyalty to the service. The service now only had eight care staff and a lot of care calls were covered by agency staff. Because of the way work rotas were organised there was a lack of continuity of care for people. Whilst two people we spoke with enjoyed seeing different care staff, the others wanted to be looked after by regular carers.

When we inspected the service in September 2017, this is what we wrote. People were asked by what name they preferred to be called and other choices and preferences that were important to them. A 'pen picture' was recorded about each person detailing their family and working life - these gave a real good sense of what the person was like. Whilst this is good practice and would enable the care staff to provide a person-centred service, the reality was the care staff were rushed and therefore had to be task orientated.

On 15 February 2018, the first day of this inspection we looked at the log of compliments received by the service. The file was empty. When we returned to the office on 22 February, the acting manager told us this had been updated. There were two retrospective entries from December 2017, one saying thank you to the care staff who were hard working and pleasant and the other saying "thank you for all your support". The acting manager had completed three of the compliment forms, each of these were in respect of named staff members.

Requires Improvement

Is the service responsive?

Our findings

When we inspected this service in September 2017, it was not consistently responsive to people's care and support needs and we rated this area as Requires Improvement. This was because people and their relatives were not listened to. Any complaints that had been made had not been acted upon (breach of regulation 16 of the Health and Social Care Act 2008 (HSCA 2008)).

Complaints were still not being dealt with in line with the registered provider's complaints procedure. We looked at the complaints log. On 15 February 2018 there was one hand written letter from a person complaining about insufficient notice about timings of care calls. They also had to continually call the office to find out what was happening. There was no evidence the complaint had been responded to. When we returned to the office on 22 February 2018 a retrospective record had been made of the action taken by the registered provider. Prior to the inspection, we were made aware that a person who had used the service was making a formal complaint to the registered provider. The complaints log had not recorded this however, we know the complaint was made because of a telephone conversation we had with the providers representative. People and their relatives we spoke with during this inspection told us they had raised many complaints but these had not been recorded. There was a trend in their complaints, having to constantly telephone the office to find out who was coming and when, last minute changes, calls being shortened and quality of care provided. The registered provider, by not recording all concerns and complaints made, was missing an opportunity to put things right and to make improvements.

This is evidence of a continued breach of Regulation 16 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People were involved in developing their care plans however, the service they received did not always follow the plans. One relative told us their brother was not having all of their personal needs met. The relative told us they had informed the care staff about the best way to approach the person who was living with dementia, but they did not listen to her. Another relative said, "The timing of a care call does not always consider the other care arrangements that are in place. This causes problems and they (Evoke) don't seem to care about the impact this has". People using the service made the following comments: "Some staff rush me and I am 99 years old", "The timing of all my visits are not ideal but they don't want to hear that", "I am not satisfied with the service I get and no one has come to review my care plan" and "My care plan is very good but it does not match the service I receive".

People's care records were kept in people's own homes and a copy was kept in the office. We looked at a sample of care plans and found then to be detailed and informative. They described how the planned care was to be provided and how many visits per day or per week the care staff were scheduled to make care calls. The care plans provided a clear picture of the person and their care and support needs and their individual choices and preferences. A 'pen picture' had been written for each person and gave an insight in to the person's family and work life. We suggested that a timetable be devised for each person showing how the agreed weekly care calls were arranged.

People's care needs were not regularly reviewed. Of the 19 care plans, we looked at five had not been reviewed since 2016. Some of the others had been reviewed at the beginning part of 2017. The acting manager informed us the newly appointed senior team leader had done most of the others but the files had not been updated.

People were provided with a copy of the service user guide and a summary of the statement of purpose and these were kept in the care files in their homes. The guide provided key information about the service, contact telephone numbers, out of office hours arrangements and the complaints procedure. We noted the statement of purpose was still incorrect, this had been pointed out at the last inspection in September 2017.

Inadequate

Is the service well-led?

Our findings

When we inspected this service in September 2017, it was not well led and we rated this area as Inadequate. This was because people felt the service was disorganised, they were continually being let down and did not receive the support that had been agreed. People spoke about the rudeness of named staff members. Care staff reported about not being treated well and being bullied into taking on extra calls and not being listened too. This was a breach of regulation 10 of the Health and Social Care Act 2008. The service was also in breach of regulation 17 of the HSCA 2008 because of a lack of quality assurance measures to assess and monitor the quality and safety of the service. The registered provider's statement of purpose was incorrect and contained the wrong information about the management arrangements and the business set up. This was a breach of regulation 12 of the Care Quality Commission (Registration) Regulations 2009 (part 4).

At the time of that inspection, the registered provider was not carrying on and managing the service. This role had been handed to a family member of the registered provider. The registered provider is now involved with the service again and being supported by other family members. These family members do not have a health and social care background and neither them or the registered provider have a good insight in to the legislative requirements in delivering a care service.

The registered provider and other family members were unfamiliar with the CQC guidance for providers on meeting the regulations booklet or the key lines of enquiries that form the basis of our inspections. The service continues to be inadequately led.

This is a breach of Regulation 4 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had failed to display their performance assessment (quality ratings poster). In response the registered provider said they were unaware they needed to do this.

This is a breach of Regulation 20A of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider's statement of purpose was incorrect in September 2017 and continued to be incorrect now. This still stated that the person officially registered to carry on the business was the family member we met in September 2017. It still referred to a registered manager who had not been working for Evoke Home Care for a long time. Service delivery still did not meet the aims and objectives set out in this document.

This is evidence of a breach of Regulation 12 of the CQC (Registrations) Regulations 2009 (Part 4).

The quality assurance measures continued to be inadequate. One of the non-registered family members asked us what a good quality assurance system should look like. They then clarified this with, "or should we know and get this organised?". The policy we looked at stated they would seek the views of people using the

services and their relatives, use staff meetings to gather staff feedback and undertake audits to check on the quality and safety of the service.

There were no records of any audits having been completed since the last inspection in September 2017. No service user, staff or stakeholder survey had been completed. We were informed no accidents or incidents had occurred since the last inspection, previously there had been no analysis of any of the events to look at what had happened prior to this happening. We have already referred to the fact that complaints were not handled correctly. This meant the service continued to miss the opportunity to prevent reoccurrences and make improvements. In September 2017, some of the care records that were kept in people's homes, were returned to the office on a monthly basis. These included the visit notes and the medicine charts. These were then checked to ensure they had been completed properly. The acting manager was unable to locate any of these records, which inferred this checking process had not been happening.

In November 2017, we had a meeting with the registered provider and another person who was supporting them. At that meeting, it was agreed that the service would submit weekly statistics showing late, missed or shortened care calls. The service did this until the end of February 2018. On the 13 and 15 March 2018 we emailed the service and reminded them we had not received these details on 2 March or 9 March. We asked these to be submitted along with the statistics for week ending 16 March 2018. The registered provider did not respond to this email or supply the information.

This is evidence of a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had promoted one of the team leaders to the post of acting manager at the beginning of January 2018. The care coordinator who had been in post in September 2017 no longer worked for the service. The other team leader who had been in post in September 2017 no longer worked for the service.

The feedback we received from people, their relatives and staff at this inspection was still on the whole negative however, there was recognition there had been some improvements. People/relatives talked about constant last minute changes, having to contact the office all the time, no reviews of care packages and being looked after by loads of different care staff. Care staff did not refer to being bullied at this inspection but did say they were always being asked to take on extra calls. They said, "We are told things are getting better", "The office is chaotic", "People tell us they don't like the agency staff visiting" and "The training is poor". Care staff said the feedback they received from people using the service was always grumbles. Positive comments were received regarding named care staff (one of them being an agency worker) and also where people received a consistent service from the same member of staff.

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 12 Registration Regulations 2009 (Schedule 3) Statement of purpose The registered provider must keep the statement of purpose up to date and review it regularly to ensure it is up to date Regulation 12 (2) and (3).

The enforcement action we took:

Notice of decision to cancel the provider's registration issued 21 December 2017 but appealed against.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider must ensure that each person receives the care and support that meets their specific needs and had been agreed upon. Regulation 9 (1) (a-c)

The enforcement action we took:

Notice of decision to cancel the provider's registration issued 21 December 2017 but appealed against.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered provider must ensure that complaints made are handled correctly so that improvements can be made where identified. Regulation 16 (1) and (2).

The enforcement action we took:

Notice of decision to cancel the provider's registration issued 21 December 2017 but appealed against.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

	The registered provider must have systems in place to assess, monitor and improve the quality of the service provided. Regulation 17 (2) (a).

The enforcement action we took:

Notice of decision to cancel the provider's registration issued 21 December 2017 but appealed against.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider must ensure there are safe staff recruitment procedures in place. Regulation 19 (2 and 3).

The enforcement action we took:

Notice of decision to cancel the provider's registration issued 21 December 2017 but appealed against.

Regulated activity	Regulation
Personal care	Regulation 4 HSCA RA Regulations 2014 Requirements where the service providers is an individual or partnership The registered provider must ensure they have the necessary qualifications, skills and experience to carry on the regulated activity. Regulation 4(5).

The enforcement action we took:

Notice of decision to cancel the provider's registration issued 21 December 2017 but appealed against.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider must ensure staff receive sufficient training to enable them to provide the care people need. Regulation 18 (2) (a).

The enforcement action we took:

Notice of decision to cancel the provider's registration issued 21 December 2017 but appealed against.