Enterprise Care Group Ltd

Enterprise Homecare

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

Summary of findings

Overall summary

We carried out an inspection of Enterprise Homecare over two days on 9 and 11 August 2016. The first day of inspection was unannounced.

Enterprise Homecare is a domiciliary care service providing personal care and support to people living in their own homes in the community. The hours of support vary depending on the assessed needs of people. At the time of our inspection the service was delivering care to 297 people.

There was a registered manager in post. 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'. 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.

During this inspection we found three breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we have told the provider to take at the back of the full version of the report.

We found improvements were needed to ensure that staff were accurately using the electronic call monitoring systems in place. Analysis of electronic call monitoring records highlighted that the leaving times were being incorrectly recorded by office staff after care workers had failed to log out.

The electronic call monitoring records data were not always factually accurate in respect of the length of time the care worker had spent providing care to people. The evidence we were presented with indicated that actual time spent undertaking personal care was less than that commissioned for some people.

People had an assessment prior to receiving a service and risks were identified before the commencement of care. Managing those identified risks was not always made clear for staff as risk assessments that were in place were basic and did not contain enough information.

Staff were trained and competent to administer medicines and new documentation meant this was recorded appropriately. Staff knew their roles and responsibilities and were knowledgeable about the risks of abuse and reporting procedures.

Some people who used the service lived alone and staff required the use of a key to access their house. Keys were appropriately stored in a 'key safe' outside houses and three people we spoke with receiving a service were satisfied with the way this was managed.

Recruitment processes included the completion of pre-employment checks prior to a new member of staff working at the service. This helped to ensure that staff members employed to support people were suitable and fit to do so. People who used the service could be confident that they were protected from staff that were known to be unsuitable to work with vulnerable people.

There was a thorough induction process in place with appropriate training provided for those with caring roles and responsibilities which included face to face training in a classroom setting followed by the "shadowing" of more experienced colleagues. Feedback from staff about the induction process was positive.

The service was adhering to the principles of the Mental Capacity Act, 2005 which meant that care staff supported people to make their own choices about their care. Before any care and support was provided and when appropriate, the service obtained consent from the person who used the service. This was not an element of mandatory training however, but the registered manager assured us that it would be introduced.

We saw care records lacked detail with regards to person centred care and focused on tasks that were required by the care worker. Despite this care staff displayed an awareness of person centred care and gained knowledge about likes, dislikes and preferences from talking and listening to people receiving the service.

The service had a complaints policy in place and we could see that people using the service were aware of how to make a complaint. Formal complaints were acknowledged although it wasn't clear if this was within correct timescales or what feedback had been given to the complainant. People we spoke with did not always feel that complaints were handled or resolved effectively.

Staff told us they felt they were able to put their views across to senior staff and to management and we saw examples of this from minutes of meetings and supervision records.

The service undertook some audits to monitor the quality of service delivery. We saw a number of audits in place including medication audits and spot checks on care staff completing visits. Electronic call monitoring logs had not been audited and the errors relating to the timing of visits had not been identified. The provider had failed to ensure that people were adequately protected from risks inherent with the timing and coordination of calls. The submission of notifications to the Care Quality Commission had not always

happened. These are required by law.

We found the service had up to date policies and procedures in place, which covered aspects of service delivery including safeguarding, medication, whistleblowing, recruitment, complaints, equality and diversity, moving and handling and infection control.

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.

Electronic call monitoring records were not accurately completed. Staff were not staying for the whole duration of the commissioned care visit. This had placed vulnerable people at risk of harm.

Risk assessments did not always give clear and specific guidance as to how staff should manage people's risks.

Recruitment processes were robust. All pre-employment checks were undertaken including DBS checks.

The service had procedures for safeguarding people from abuse but had failed to notify the CQC of a recent safeguarding incident, as legally required to do so.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received a thorough induction prior to commencing work. Supervisions and appraisals were carried out regularly, as per company policy.

People we spoke with said they were able to express their views and make decisions about their care and support.

Staff were not provided with visit schedules that realistically enabled them to attend to people for the correct length of time.

The service was following basic responsibilities about the Mental Capacity Act 2005 and people's consent to care however this was not an element of mandatory training.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us they were satisfied with their regular care workers. Staff were kind and caring but this was not always consistent.

People told us they were treated with dignity and respect.

Staff supported people in a person-centred way even though this information was limited within the care plan.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's concerns and complaints were investigated but things did not always change after making a complaint.

The service gathered feedback from people but there was no evidence that this was acted upon.

The service responded to changes in need and updated care plans in light of these changes.

Is the service well-led?

Inadequate

The service was not well-led.

People who used the service were satisfied with the quality of care they received overall but did not consider the service to be well led.

The submission of notifications to the Care Quality Commission had not always happened. These are required by law.

Staff felt supported by management but the co-ordination of calls was not managed well. The provider had failed to ensure that people were adequately protected from risks inherent with the timing and coordination of calls.

Although some audits were in place audits of call monitoring logs had not been done and errors contained within these had not been identified or acted upon accordingly. There were serious shortfalls in the maintenance of accurate record keeping and the overall management of the service.

Enterprise Homecare

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 took place on 9 and 11 August and was unannounced.

The inspection team included one adult care inspector, who spent time at the office and visited people in their own homes, and an expert by experience who contacted people by telephone to obtain their feedback about the quality of the service they received. An expert-by-experience is a person who has personal experience of using services or caring for someone who uses this type of care service.

Before the inspection we 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 provider asked for an extension on this but then did not submit the PIR prior to the unannounced inspection taking place. We also gathered and reviewed the information we held about the service, including the statutory notifications received since our last inspection. A notification is information about important events which the provider is required to send us by law.

We spoke with commissioners of the service to gather their views of the care and service and contacted health care professionals who had had recent involvement with the service.

At the time of the inspection, there were 297 people using the service which employed 90 members of care staff. We contacted ten people who used the service and also met face to face with four more people and two relatives in their own homes to seek their views about the agency.

During the inspection we spoke with the registered manager, two care co-ordinators, an administrator and five care workers. We looked at seven people's care records, four personnel files, supervision records and staff meeting minutes. We looked at medicine administration records and records in relation to the management of the service such as checks regarding people's health and safety. We also looked at staff

recruitment, training records, compliments, quality assurance and audit records.

Inadequate

Is the service safe?

Our findings

People told us they felt safe using the service. They told us they felt safe with care staff and free from bullying or abuse. One person told us, "I use a stand aid. They help me with that. Yes - I feel safe." We found practices at the service did not promote people's safety.

The registered manager explained that an electronic call monitoring system was in place. Staff were able to use the telephone in people's houses free of charge to log in to indicate arrival and log out when leaving a property. This, when used, then supported evidence to the provider and commissioners of services that people were receiving correct levels of care as identified within care plans.

The call monitoring facility was not being used by all staff we were told for a number of reasons. Some people receiving a service did not have access to a landline telephone. Others had not provided permission for care staff to use their telephones. We saw that some staff logged in when arriving at a person's house to deliver personal care, but staff did not always log out when leaving. When this occurred support staff based in the main office were able to do this remotely on behalf of care workers, indicating therefore that the call had been completed.

We looked at one member of staff's electronic monitoring records in more detail, and analysed logs made for all visits undertaken over a period of two days in July. We saw that over the two day period the member of staff had undertaken 25 visits to nine clients and had correctly used the system to log into 21 visits in total. The office had logged the staff member in to the remaining four visits where a telephone was not available and the code CNP had been used to indicate the client did not have a telephone.

Closer examination of the 25 visits undertaken in two days showed us that the staff member had not logged out from any, but had relied on the office to complete these call times. Records showed us that the office was logging the care worker out of visits based on the expected or commissioned duration of the calls, for example after 30 minutes, 45 minutes or one hour, not based on the actual time spent providing personal care to people. As the staff member had already logged into their next calls using the telephone system some time before the end of previous calls had been recorded, it highlighted to us that the office was inflating the amount of time a care worker was spending with people receiving a service.

We could see from the records we viewed that people were not receiving the allocated amount of time for the majority of visits. This meant that people were at risk of harm as care workers were not staying for the whole duration of the commissioned call. People's safety was impacted upon and the electronic call monitoring system could not be relied upon to evidence that personal care calls had actually occurred.

Care plans we looked at in the office contained information in relation to risks that had been identified for individuals, for example in relation to their mobility, nutrition, the administration of medicines and in the event of a fire. However the assessment of risk identified for individuals had not always been completed and therefore, there was no evidence that they had been mitigated against.

In the four properties we visited we saw only one completed risk assessment on file. This person was identified as having poor mobility and at increased risk of having falls. Staff told us about one property with a 'cluttered' environment. They told us this made the delivery of personal care difficult but no risk assessment on the environment had been carried out. Not enough information was made available to care staff and paperwork in place did not fully outline what actions carers could and should take to reduce the risks posed to individuals.

We found the service to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because care and treatment was not being provided in a safe way for people using the service.

The registered manager told us there were enough staff employed to meet people's needs, and we found few instances of people failing to receive a planned care visit. However, the feedback we received indicated that people did not always receive regular carers and were affected by the frequent late arrival of carers.

To ascertain what impact this had on the people using the service we spoke to a number of people about the reliability of the staff and the agency. One person we spoke with told us, "My main gripe is with late calls. They [the carers] sometimes arrive on time but not always. Timing is critical to me and late calls do impact on my freedom to go out when I want."

One person said: "The care is generally good and the carers, the regular ones, are helpful and respectful." Another told us, "We do get regular staff, they can be three different ones, but they don't always let me know if they will be late." People told us that care was more unreliable at weekends and inconsistent when regular staff were not available.

One family member we visited and spoke with described their relative's regular carer as being "very good." If they were off the relative cancelled all the calls and provided support themselves. There had been no consistency with carers sent to cover and this did not suit the vulnerable, older person receiving the service who was living with a diagnosis of dementia. The relative added, "It might be me, I might be fussy. I want the best for my [relative]."

The number of late calls and the frequency with which care workers left calls early highlighted that there were insufficient numbers of staff to undertake all the required calls.

We found the service to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the service recruited staff and found it was safe. We looked at five staff files and found them to be complete and in good order. We saw that applicants were required to undergo basic numeracy and literacy tests and did not progress to interview stage unless a satisfactory pass was gained in both subjects. There was interview paperwork in place to record candidates' responses and the questions were relevant to the role of care worker. This meant that the provider ensured that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely.

We looked at staff recruitment records and saw that appropriate checks had been undertaken before staff began working for the service. Disclosure and Barring Service (DBS) checks were carried out and references were obtained, including one from the staff member's previous employer where possible. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also helps prevent

unsuitable people from working with children and vulnerable adults. Proof of identity was obtained from each member of staff, including copies of passports and evidence of the right to work in the uk where necessary.

We checked the medicine administration records (MAR) for the people we visited and found the arrangements in place were safe. People we spoke with who had their medicines managed by care staff said it was done well. We noted that the registered manager had recently reviewed and improved the medication administration recording template and had informed the Care Quality Commission prior to its implementation. A relative of someone receiving the service told us, "The medicines recording form works better, the form indicates that they've taken it." Prior to this staff were just recording in daily notes that medicines had been given to people. The new form had the facility to record that medicines from blister packs had been given, creams applied and required a staff signature.

Some people who used the service lived alone and staff required the use of a key to access their house. Keys were appropriately stored in a 'key safe' outside houses and three people we spoke with receiving a service were satisfied with the way this was managed.

Staff received training on how to recognise abuse and possible harm to people using the service. They understood what abuse was and the action required if they should encounter it. Staff were also aware of how to raise a safeguarding alert and when this should happen and told us they would be confident in doing this.

There had been a recent safeguarding incident raised with the manager prior to our inspection. This was still on going at the time of our inspection and we could see that the registered manager had followed company procedures in line with the Local Authority's Safeguarding protocols and was liaising with other professionals in respect of this. Shortly after the inspection we received intelligence that a vulnerable person had had several missed visits over a bank holiday period. This had placed the person in danger and put them at risk of harm. The service failed to notify CQC about this incident, as is their legal obligation.

Requires Improvement

Is the service effective?

Our findings

People told us they thought staff knew how to do their jobs and regarded staff to be adequately trained for the care worker role. People were complimentary of their regular carers however people we spoke with told us support was inconsistent if regular carers were absent for any reason or care workers left calls early. One relative told us, "I suppose they are trained enough to know what they are doing, but they don't always give us the full length of time and sometimes leave early."

Care staff we spoke with on the whole did not feel rushed or under pressure unless they were given "extras." Extras were when staff were approached to cover for colleagues who were absent from work at short notice and were given extra calls for the day. One staff member said, "Sometimes you can be a bit rushed if you have extras."

There was a robust induction programme in place. Successful recruits were provided with an induction workbook at the start of their employment. Elements within this related to principles of care, safeguarding, promoting independence at meal times and the expectations of a support worker. Once completed and signed off these were retained on the staff personnel files. We saw positive comments gathered from staff who had participated in recent inductions. When asked the question if the induction had provided them with information and practical skills to carry out tasks, one new staff member commented, "indeed."

We saw a training matrix which outlined all training staff had undertaken to date and this was colour coded to indicate when refresher training was due. We saw that all staff had completed medication principles and safeguarding training which was currently valid. Other mandatory courses were on the matrix and included health and safety, dementia, basic life support, moving and handling update, food hygiene, infection control and fire safety.

Supervisions and annual appraisals were occurring as per company policy. Every member of staff had received an annual appraisal in January 2016; staff found these beneficial. We saw that supervisions were undertaken every three months. These were mainly done in the office but practical supervisions included spot checks on staff undertaking care visits to people in their own homes. During these supervisions co-ordinators checked that care practices were carried out correctly and to the satisfaction of people receiving the service.

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.

The registered manager told us that if they had any concerns regarding a person's ability to make a decision they worked with the local authority to ensure appropriate capacity assessments were undertaken. This was done to ensure a person was not deprived of their liberty.

Staff had not received specific training on the MCA although we were later provided with evidence that dementia awareness was a topic covered during the induction. Three staff members we spoke with told us about the circumstances they needed to be aware of if people's mental capacity to make certain decisions about their care changed. They told us they would raise it with management if they considered a person's mental capacity was fluctuating or if they were low in mood.

This showed us that there were mechanisms in place to raise concerns and that staff recognised the importance of highlighting when a person's decision-making ability was possibly impaired. We spoke with the registered manager about the lack of training in this area and was assured that this would be addressed and introduced. We will check on this aspect when we next inspect the service.

Our discussions with staff and people using the service showed consent was sought and was appropriately used when delivering care. People we spoke with who used the service said they were able to express their views and make decisions about their care and support. One person told us, "I am very clear with my carers as to what I expect." Staff recognised the importance of consent prior to providing care. One said, "I would always ask and I always give a run down of what I'm going to do." Staff we spoke with said they encouraged people to make their own choices and they provided care and support with consent from the person.

People who received a service had differing levels of support with eating and drinking. Some people were supported at mealtimes to access food and drink of their choice. Care staff told us that food preparation at mealtimes was either preparation of a snack meal, for example soup or sandwiches, or the heating of a ready meal in a microwave oven. Some people had meals prepared by family members which required reheating. Care workers were aware of the importance of ensuring people had access to adequate food and fluids, had received training in food safety and were aware of safe food handling practices.

Requires Improvement

Is the service caring?

Our findings

People we spoke with all agreed that staff were caring. Comments included, "I do feel safe and they are caring"; "Care staff are kind, they treat me well", and "[Staff member] is really nice. [Name] doesn't just do her job and run off, we have a little natter."

People we spoke with were particularly complimentary about their regular care workers. They told us that staff were warm,friendly and established a good rapport with them. One person commented that they had been provided with a regular care worker, and things had improved. "It was a bit hit and miss before," they told us. "[Staff member] knows what I like. I have two boiled eggs with toast." A relative we spoke with also spoke highly of their regular care worker. They told us, "[Staff member name] is very cheerful. She chats to my mum, she has a laugh with her."

On occasions people told us visits had been missed and they had been sent alternative care workers. One told us, "I have been missed out at weekends and they have sent me a male carer who doesn't know what to do." People we spoke with did not regard the care they received at weekend as consistent as that received during the week. We spoke with the registered manager about this who admitted it was sometimes necessary to send a care worker a person might not usually have. They considered this was a better option than the person not receiving a domiciliary care visit. The manager told us they would try and ensure that people were provided with a core team of consistent carers in the future.

People told us they had been asked what care and support they needed and how this should be provided. They told us that staff listened to them and were good at explaining things to them. Care staff told us how they knew individual needs of the person they were supporting. They told us that they looked at people's care plans which contained information about people's care and support needs and knew the level of support and reassurance to give.

Care plans did not contain detailed information about a person's life history or their likes and dislikes, but people we spoke with confirmed that staff knew this information and met their needs accordingly. Staff we spoke with recognised that people were individuals and treated them as such. A member of staff told us, "I do the same task very differently for different people."

Staff were able to outline to us the cultural differences that people using the service had and how they met these needs. They told us about the different foods people ate, differences in preparation and how people from a particular cultures liked to be washed. They demonstrated knowledge of different faiths and we were assured that these were respected and followed by staff when providing personal care.

People told us that carers did respect their privacy and treated them with dignity. Staff we spoke with gave us examples of what they did in the caring role to maintain people's dignity. "I wouldn't just walk in," one staff member told us. "I always knock before I go in," another said.

Other staff told us they would close curtains and ensure the person was covered up as much as possible

when receiving personal care. Someone receiving a service commented that care staff always treated them with respect and made sure they were comfortable before leaving. We were assured that staff had a good understanding of maintaining dignity and how this was embedded within their practice and interactions with people.

Staff were able to outline to us examples of when they promoted independence for the people they supported. They gave us examples of encouraging people to dress themselves, wash themselves and eat independently. One person we visited told us, "I just wash my face. I can do that and they let me." This showed us that staff understood the understood the importance of allowing a person to continue to do things for themselves and how this benefited the person.

Care records were stored securely. Information was kept confidentially and there were policies and procedures to protect people's confidentiality.

Requires Improvement

Is the service responsive?

Our findings

We looked at care plans kept at the office and also those in people's homes. The care plans mapped out what was expected of carers at each visit and included aspects of care in relation to skin integrity; mobility; continence care; medication; eating and drinking.

Care plans lacked person-centred information and were predominantly task orientated, with identified risks highlighted. Daily notes were maintained illustrating the care each person had received. These notes were brought to the office on a monthly basis, to be reviewed and audited and to make sure care was responsive to people's needs.

There was evidence of people's choices being promoted, such as if they wished to go out, if they needed a GP appointment or in relation to meals being offered. Details of people's personal care requirements were noted on their records for staff to be able to give the right level of support.

We saw examples of when the provider had been responsive to people's choices and requests. One person had requested that only male carers provided care and told us, "I did request a switch to a male carer and I got one so that is a good mark for them." This example demonstrated this person's personal choices and preferences were respected and upheld.

We saw that another person had been referred for an urgent moving and handling assessment after care staff reported a change in need, due to a deterioration in their mobility. As a result of the referral the local authority responded and the package was increased to include double up cover for every visit. We saw that the service updated the care plan to reflect the change in need and the increased support.

There was a complaints procedure information available in the service to assist people. Staff we spoke with said they would ensure people's views were heard should people have cause to complain. One member of staff we spoke with confirmed what action they would take in the event that someone wanted to make a complaint. They told us, "I would tell them [the client] to ring the office. The details are in their file."

People and relatives we spoke with all said they knew how to make a complaint if they were unhappy about the service and would be confident in doing so. Seven of the ten people contacted by telephone had made a complaint previously, however only three people thought that things changed or improved as a result of making the complaint. One person using the service told us, "I have made a complaint but not much changed and it did not surprise me." Another person added, "You get promises but no action and no call-back," and a third person told us, "When I did have to make a complaint nothing much changed."

We asked the registered manager for a copy of the complaints log and this was sent to us. The original complaints log we were sent did not indicate that the registered manager had responded to all complaints appropriately or within appropriate timescales, however a more complete version was later received. This evidenced that the provider responded to complaints made to them about aspects of the service. We saw examples of correspondence in relation to complaints that had been raised by the local authority. Evidence

was provided to the local authority in response to these complaints, however the provider should also ensure that people receiving a service and making a complaint are kept fully informed with regards to the outcome of the complaint.

Inadequate

Is the service well-led?

Our findings

A registered manager was in post at the time of our inspection. They assisted us with our enquiries throughout the inspection.

We found that there was inadequate governance, leadership and management oversight within the service which had led to the concerns identified within this report. The information was fed back to the registered manager both during and following the inspection.

We approached a selection of people and asked them for feedback in relation to the management of Enterprise Homecare. These included people using the service, their relatives, staff and other professionals involved with the provider. We received mixed feedback about the management and leadership of Enterprise Homecare.

When asked whether the service was well-led comments we received from people using the service included, "Very strange", "Different", "Not too bad" and "Satisfactory overall." One care worker considered there was 'room for improvement', especially with regards to communication between office staff and care staff.

The common theme amongst those we spoke with was that regular care staff were 'very good' but if regular carers were off for any reason then other care staff were required to cover and service delivery suffered.

Following the inspection a number of safeguarding referrals were received from the local authority in relation to missed visits and late calls. The majority of these had been raised by relatives or by third parties but the local authority had made the provider aware of these. One was in relation to missed visits which resulted in a vulnerable adult being left without support for nearly 24 hours. This example is classified as a notifiable incident and as such this should have been communicated to the CQC, as is required by law.

We found this was a breach of Care Quality Commission (Registration) Regulations 2009: Regulation 18.

Staff meetings addressed operational and professional matters, such as health and safety, good record keeping and care documentation. We saw minutes from the last staff meeting held in March 2016. Staff had been informed about the pending implementation of the combined medication administration and visit log form. Compliments had been received from a number of professionals and these were shared with staff at the meeting. Staff were also reminded to log in and out using the electronic call monitoring system wherever possible and performance in this area was described as "appalling" at the time. We could see at the time of inspection that this had not improved and the registered manager had not identified this issue.

Staff we spoke with said they felt able to contribute to staff meeting discussions. Staff told us they felt they were able to put their views across to seniors and to management and we saw examples of this from minutes of meetings. One care worker we spoke with told us, "You can raise anything you want to, they will listen to any suggestions." Staff told us they were comfortable in approaching the registered manager or the

care co-ordinator, depending on what the issue was. Staff told us management were fair, supportive and always available. One staff member told us, "The registered manager is very flexible. One of the best managers I've worked with." They went on to tell us that the manager was hands on and covered calls if and when this was necessary.

There were some systems and procedures in place to monitor and assess the quality of some aspects of the service provision and regular spot checks were done to ensure staff were delivering the care people wanted. We saw examples of spot check supervisions undertaken with staff whilst they were carrying out visits to people using the service. These spot checks noted the arrival time of the care worker, their appearance, whether uniform was being worn and commented on how they involved the customer. One staff member was noted to be "polite and helpful" in asking the person what they wanted to wear and what they wanted to eat. These spot checks do not seem effective in addressing the issues identified at this inspection.

The service undertook audits to monitor the quality of service delivery. We saw that audits were carried out on daily communication and medication logs that had been collected from people's properties and brought into the office. Where errors or failings had been identified we saw that staff had been contacted and errors discussed with them.

However more significantly the serious issues we found, including incorrect usage of the electronic call monitoring system and the frequent late arrival and early departure of care workers, meant that the leadership and management needed to be improved. Audits of call monitoring logs had not been done and the errors contained within these, often done by staff based in the office, had not been identified by the provider and acted upon accordingly. Additionally the service was not keeping an accurate record of the delivery of the service, given they were adding inaccurate information to the system that did not reflect the actual service received. This lack of oversight and management meant that the provider was placing people at risk of harm from inadequate management of the call system and delivery of service. The provider had failed to ensure that people were adequately protected from risks inherent within the timing and coordination of calls.

We checked to see if the service sought customer feedback. We saw that questionnaires had been issued to people using the service and their relatives. A number of these had been returned to the office. We saw positive comments such as, "My regular carers are very good," but the timing of calls was a common issue raised by people using the service. We saw the following comments: "I often phone the office", "I phone the office if the carer is late", "Some calls are very late" and "Not enough time between two calls. Gap is too small." The last comment related to the tea time and bed time visits as the latter was being done too early. There was no evidence that these comments had been followed up or acted upon.

We judged the service to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the governance systems in place were not robust to ensure risks were being managed through the quality review of the service.

The service had up to date operational policies and procedures in place, which covered all aspects of service delivery including safeguarding, medication, whistleblowing, recruitment, complaints, equality and diversity, moving and handling and infection control. Those which were relevant to staff were also contained within the staff handbook, a copy of which was emailed to newly appointed staff during induction. Included within staff handbooks were the company's social media policy, gifts policy and maintaining boundaries policy.

We saw the recently introduced medication administration and visit log form had been implemented. People we spoke with, their relatives and staff told us that this was an improvement to the service. The registered manager had other ideas for future improvements they wanted to make and how they wanted to develop the service but these had not yet been put into practice.

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 Registration Regulations 2009 Notifications of other incidents Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Two missed visits resulted in a vulnerable adult being left without support for nearly 24 hours. This notifiable incident should have been communicated to the CQC, as is required by law.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 of the HCSA 2008 (Regulated Activities) Regulations 2014 - Staffing People did not always receive regular carers and the quality of their care was affected by the frequent late arrival of carers. The number of late calls and the frequency with which care workers left calls early highlighted that there were insufficient numbers of staff to undertake all the required calls. Regulation 18 (1)

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 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment People were not receiving the allocated amount of time for the majority of visits. People were at risk of harm as care workers were not staying for the whole duration of the commissioned call. People's safety was impacted upon and the electronic call monitoring system could not be relied upon to evidence that personal care calls had actually occurred. The assessment of risk identified for individuals had not always been completed. Not enough information was made available to care staff and paperwork in place did not fully outline what actions carers could and should take to reduce the risks posed to individuals. Regulation 12 (1) (2) (a) (b)

The enforcement action we took:

Warning notice for Regulation 12

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 - Good Governance There was a failure to assess, monitor and improve the quality, safety and suitability of the service. Audits of call monitoring logs had not been done and the errors contained within these, often done by staff based in the office, had not been identified by the provider and acted upon

accordingly.

There was evidence of poor and false recording in relation to the electronic call monitoring system.

Feedback from people receiving a service had been sought but there was no evidence to support that this had been acted upon.

Regulation 17 (1) and 2 (a) (e) (f)

The enforcement action we took:

Warning notice for Regulation 17