

Westminster Homecare Limited

# Westminster Homecare Limited (Chelmsford)

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

# Summary of findings

## Overall summary

Westminster Homecare Limited (Chelmsford) provides support to people in their own homes. It does not provide nursing care. At the time of our inspection the service was supporting approximately 200 people.

At our previous inspection in September 2014, we found care plans did not always outline people's needs and did not give clear guidance to staff on how to support people. At this inspection we found the registered manager had addressed the concerns we had raised and updated the care plans for people using the service.

The inspection took place on 18 and 19 July 2016 and was announced.

A registered manager was in post at the service. 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.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

New people did not have their needs and risks assessed in a timely manner before they started receiving care. Staff did not therefore have the necessary information available to minimise any potential risks and meet people's needs safely.

Staff were recruited safely, however there were not sufficient staff to manage risk and meet people's needs as outlined in their care plans. People were not assured that the timings of support would meet their personal circumstances and preferences.

Although, staff were trained to administer medicines, they did not consistently follow the organisation's procedure when recording the support provided with medicines. It was therefore not always possible to be sure people had received the correct medicines. Changes in visit times meant some people's medicines were not administered in a timely manner.

There were procedures in place to safeguard people from abuse and unnecessary harm, and staff were able to describe how they would use these to keep people safe. Care plans outlined the risks staff needed to be aware of when they worked with people.

Staff received comprehensive training and induction, however checks to ensure new staff had the necessary skills prior to starting support were not sufficiently robust. Some staff did not have the skills to effectively support people with dementia.

Care plans outlined how to support people who were not able to make a decision about the support they received. Staff were aware of the need to offer choice and seek permission before providing care. Staff supported people to ensure their dietary needs were met however; they did not always follow guidance in care plans where people with dementia needed additional support to have enough to eat and drink. People were supported to access health professionals when required.

Where people were cared for by staff they knew, care workers were respectful, kind and compassionate. However, changeable rotas and staffing meant people felt they were at times supported by care workers who did not have the necessary time or knowledge about their needs.

Where care plans were in place for people these were detailed and personalised. People and their families, as appropriate were involved in the review of their support. Communication between staff was not always effective so people did not always receive continuity of care. People received a personalised response to formal complaints, however were dissatisfied with how informal complaints and concerns were dealt with.

There were measures in place to monitor the quality of the service, whilst overall these systems worked well; there were gaps, where the manager was not able to demonstrate they could monitor the support people were receiving.

Morale was low amongst staff who felt they were being asked to carry out an unrealistic number of care visits. The manager had not ensured the staff and office communicated and worked well together.

The manager had started to pro-actively deal with the concerns we had found during our visit. They were committed to driving improvements in the service.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement** ●

The service was not always safe.

Staff did not always have enough information about people's needs.

Whilst staff were recruited safely, there were not always enough staff to meet people's needs and care workers were not deployed effectively.

Staff had the skills to administer medicines safely; however they were not always effectively recording the support they had provided and inconsistent rotas meant medicines were not always administered in a timely way.

### Is the service effective?

**Requires Improvement** ●

The service was not always effective.

Staff did not always have the skills or take the time to effectively support people with dementia, in particular to maintain adequate nutrition.

Training and support was in place to develop staff skills to meet people's specific needs.

Staff worked within the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and were given guidance to support people to make their own choices.

Staff supported people to access health and social care services as required.

### Is the service caring?

**Requires Improvement** ●

The service was not always caring.

Some staff rushed visits and people did not feel they were treated with dignity.

Where staff had time to develop stable relationships with people, they treated them with kindness

### Is the service responsive?

The service was not always responsive.

People did not always receive a continuity of care due to changing rotas, unclear support plans and poor communication between care workers.

Some people had limited choice over the timings of their visits and the gender of their care worker.

Whilst formal complaints were responded to well, people told us informal complaints were not dealt effectively.

**Requires Improvement** ●

### Is the service well-led?

The service was not always well-led.

People and staff felt they did not have access to the registered manager. The staff team was not functioning effectively across the service and morale was low.

There were a number of systems in place to measure quality.

The manager had responded well to the concerns raised at the previous inspection and to any findings from measures to gather people and families views on the service.

**Requires Improvement** ●

# Westminster Homecare Limited (Chelmsford)

## **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 18 and 19 July 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available to respond to our queries.

The inspection team consisted of two inspectors and one expert by experience, who carried out phone calls after the visit to the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

On the day of the inspection we visited the agency's office and spoke with the registered manager, the deputy manager plus eight care staff. We visited five people who used the service and their families. We spoke on the phone to eleven people and nine family members. We met the staff supporting people at three of the visits. We contacted an additional four members of care staff by telephone. We emailed every member of care staff for their views on the service and received eight responses. In addition, three members of staff chose to email us anonymously. We spoke to four health and social care professionals to gather their views on the service.

We reviewed all the information we had available about the service including notifications sent to us by the manager. Notifications are information about important events which the provider is required to send us by law. We also looked at information sent to us from others, including family members and the local authority. Prior to the inspection we sent out a questionnaire asking people and their families to give their opinion of the service. We received 29 responses from people and four from family members. We used this information

to plan what areas we were going to focus on during our inspection.

We looked at nine people's care records and five staff records. We examined information relating to the management of the service such as health and safety records, personnel and recruitment records, quality monitoring audits and information about complaints.

# Is the service safe?

## Our findings

People were not kept safe as staff did not always have adequate information about people before they started providing care to them. Care coordinators visited people's homes and carried out an assessment of their needs but this was not always done before support started. After the initial assessment a handwritten care plan was put in place until the final care plan was completed. The manager could not easily monitor or tell us when information on people's needs was provided to staff. They could therefore not check whether sufficient guidance was in place to minimise risks to people's health and wellbeing.

Prior to our visit we became aware that a person had not had a care plan in place for over a month after they had started receiving care. The person had dementia and was not able to describe to staff the tasks to be carried out. During our inspection we looked to see whether the lack of a care plan for new people was an isolated example, and found care plans were not put in place in a timely manner when people started at the service. One care worker told us, "For a new person, there's never anything in, often up until a month."

The lack of information available to staff meant people were at risk of harm due to a lack of awareness of their care and health needs. For example, one person's finalised care plan was put in place five weeks after they had started the service. It was not clear when the care coordinators had visited the person to carry out an assessment and provide initial guidance to staff on meeting the person's needs. The person was intolerant of milk and had needs arising from dementia and we were not assured the manager had adequate measures in place to protect them from harm.

When there were no care plans in place staff told us they spoke to families, where possible. A care worker told us, "We get a brief introduction, a lot of it is common sense and we ask the families." They also phoned for verbal guidance to office staff, who often took information provided by the professionals who had referred people. Whilst some of the information on the referral form was current, this was often not the case. For example, where people had been discharged from hospital, referrals were completed by staff who were not always aware of potential risks when people were being supported in their homes.

Staff we spoke with told us the delay in providing information on people's health care needs was a concern. For example, a care worker told us, "Sometimes I might get a new package given to me, and have to phone up and ask what is expected, usually I'm told personal care, which to be honest doesn't really tell me much, it doesn't tell me for example if they have Parkinson's disease and slight dementia, and when I get to the house there is no care plan to read." Another care worker said, "We tend to find out from the service users or their family what is wrong with the service users as we are rarely told from the office what medical problems they have."

The manager told us the provider's policy required care plans to be in place within 48 hours but acknowledged this was not always the case. After our visit the manager told us they had put measures in place to resolve the concerns we had raised.

Where care plans were in place we noted there were assessments to cover any risks when supporting people, and staff were able to describe the risks to us. For example, staff described how they supported a

person to minimise the risk from them becoming breathless.

We looked at three care plans for people who used a hoist and noted that in two of these there was not sufficient guidance on the correct equipment to be used, for example which slings should be used. Regular staff we spoke to felt confident with using the equipment, however there was not adequate guidance in these two care plans for staff who were not familiar with the people being supported. Risks had not therefore been minimised for the people being supported and the staff carrying out the transfers.

Staff were aware of how to respond to emergencies and described the guidelines in place to treat people with medical difficulties or emergencies. The people we spoke with said they felt staff would take appropriate action if they were seriously unwell, or needed emergency treatment. However, one person told us that because they had so many different care staff, they were concerned individual staff might not always understand if they were simply, "having a bad day" or whether they need more urgent medical attention.

We spoke with staff who had a detailed knowledge of how to administer medicines safely, for example a care worker was aware of the risks in crushing tablets. Another member of staff told us they had received medication training before administering medicines. They were able to describe how to safely record the support they provided on medicine administration sheets (MARS) and we saw good quality recording by some staff when we visited people in their homes. People's care plans had guidance on how to administer medicines. For example, they outlined whether a person understood the medicines they were taking and highlighted any risks care workers should be aware of when administering medicines. Staff told us medicines records were checked regularly. We saw notes from a staff meeting where the manager had provided a reminder to staff on how to administer medicines safely.

Despite these safeguards, we noted during our inspection a number of concerns in the recording of the support given with medicines. We looked at one person's MARS and saw that prescribed creams were not consistently recorded. We looked at another person's records and saw that whilst these were usually completed correctly, some staff had used the daily record sheets rather than the MARS to record when a person had been supported to take their medicines. For example, one care worker had written "meds given" in the notes. This was not in line with the organisations policy, and as the notes were not well ordered it was difficult for families, other care staff and outside professionals to see what medication had been given. It also meant the manager was not able to assure themselves staff were giving people medication safely and as prescribed. We were told by a member of staff and the manager that there were checks on staff competencies; however they had failed to resolve the concerns we had found.

The manager told us rotas prioritised where medicines had to be taken at a particular time. We received feedback from three relatives that the timing of visits and changes in staffing impacted on the administration of medicines. For example, one relative told us visit times varied widely so medication was often given too close together, or too far apart. They explained, "Lunch calls should be 12-12.30pm, but they've started turning up at 1.30pm, then they can turn up for the tea call as early as 3.15pm. It's no good for medication." Another family member told us they had contacted the office about mistakes with medicines being administered. A third relative told us their relative had Alzheimer's, and although staff needed to be efficient and reliable, the administration of medicines was not consistently well-timed.

We outlined the examples we had found concerning the poor administration of medicines and the manager assured this would be addressed as a matter of urgency. A member of staff told us that all care workers were being trained in a new and improved way of recording any support given with medicines.

The registered manager had failed to assess in a timely manner the risks to the health and safety of service users and had not consistently put in place measures to mitigate any risks. They had also failed to ensure

the proper and safe management of medicines. These failings are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

Six people told us they used to receive regular weekly schedules, detailing the names of their care workers with planned visit times. They said they did not receive this anymore, and that this made them feel less secure. A relative told us, "[Person] needs to prepare for who's coming, they don't like not knowing in advance." A person told us, "The schedules haven't been coming recently, it does make a difference to me, I like to know who's coming in." The manager told us people were only given a schedule in advance when they requested this, for example if they were anxious about timings of visits. However, a member of staff told us people did not know they could still ask for them to be sent out.

We looked at the electronic rotas but were told by staff and people these frequently changed. As a result, where a person did receive a written schedule it was not always accurate. For example, one person told us they were satisfied with their care, however, "We get a bit of paper now to say who is coming, it tells us who is visiting though it's not always accurate."

We received feedback from staff, people and families that there were not enough staff to meet people's needs. For example, one relative told us their family member was meant to have two members of staff at each call, but that sometimes just one arrived, who explained they were short-staffed. The greatest impact was when staff were unwell or on annual leave. A relative told us, "The slightest hiccup occurs, and they can't cope. The carers can't manage and they moan when they come in." Another relative said, "They're really short of carers, weekends are even more of a problem." A member of staff told us there were not enough staff to cover when usual care workers were off, "They have no bank staff available, and carers go off sick all the time."

Deployment of staff was not effectively managed. Staff we spoke to told us there were frequent requests for them to take on additional visits. Two care workers we spoke to told us that they felt able to refuse additional work if it meant they would be unable to meet the needs of the people on their existing rota. They told us that other colleagues did not feel able to refuse the requests. A third care worker told us, "I am constantly being phoned asking to pick up extra which sometimes I can but when I can't no means no, something the office do not understand, instead they phone and phone and phone, text after text." One person told us, "I know that carers block their numbers, or refuse to answer their phones, so they don't get asked to take on more people."

We discussed with the manager whether additional visits were added to shifts which were already full and they told us this was not possible as the system did not allow for double bookings. However, the information we were given by staff differed from this statement. A member of staff told us, "I really feel for the on-call (the staff booking visits in) as there are too many people for the number of carers and they say 'can you just squeeze someone in'."

Staff told us the extra visits were scheduled into their travel time. We looked at staff rotas and saw there was no travel time between each visits, with each worker having a gap between a cluster of visits to accommodate travel time. Staff we spoke to told us the system worked unless a care coordinator asked them to slot additional visits into the time allocated for travel. A member of staff told us, "There is not enough travel time, calls are given back to back on the rotas." We were told that when this happened visits were either cut short, run late or missed.

We discussed our concerns with the manager regarding staffing levels and we were told that recent delays in recruitment processes and the departure of key staff had resulted in a challenging period for the service. The

manager told us they had accepted fewer referrals over the two weeks preceding our visit following the departure of a number of care staff. They advised us they were not under undue pressure from the wider organisation to take on care packages which they could not safely meet. However, the information we had gathered indicated people had been introduced into the service when there were not sufficient staff to meet their needs safely.

There were not enough staff deployed to minimise risk and meet the needs of people receiving care from the service. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two family members said visits were sometimes missed altogether, or insufficient staff turned up to safely carry out the tasks outlined in the care plans. The manager showed us the system for logging missed calls, and the deputy manager told us they were alerted to missed calls by a call from other staff, people or families. We saw that there were a low number of recorded missed calls and where these had been reported they had been dealt with effectively.

Prior to our visit, a professional informed us they had investigated how well a person with dementia was supported by the service at lunchtime. They told us the manager had not been able to provide assurances that the person had been provided with the necessary lunchtime visits, as outlined in their care plan. Likewise, during our visit to the home of a person with dementia we became aware of a number of possible missed calls which had not been recorded on the missed call log. Over a two week period there were no records for five of the scheduled lunchtime visits. The manager explained these were called 'frustrated' visits, a term used where a person said they did not need care, and these were therefore not missed calls.

At another one of our visits there were also a number of gaps in the care records and we were told this was because the person regularly cancelled. We were advised this was a low risk as the detailed tasks outlined in the care plan were not current and did not reflect the low level of support this person now required. The manager demonstrated a commitment to reviewing people's care plans where we had raised specific concerns, however we were not assured that there was a robust system in place to monitor the 'frustrated' or cancelled visits.

Staff had an understanding of what abuse was and were able to describe how they supported people to keep safe. They told us they had attended safeguarding training and were aware of signs to look for when supporting people, such as changes in mood, or unexplained bruising and would report any concerns to the manager. One care worker told us they had noticed a suspicious salesman in someone's house and were concerned for the person's safety. They reported their concerns to the office and to the person's family then went back to check to see if the salesman was still there. The manager had processes in place to record and track accident, incidents and safeguards which had been raised.

Recruitment processes were in place for the safe employment of staff. The recruitment procedure included processing applications and conducting employment interviews, carrying out references and ensuring the applicant provided proof of their identity and right to work. Disclosure and barring checks (DBS) were also completed for new staff to ensure they were safe to work with vulnerable adults. We looked at recruitment files for five staff and noted that the provider's procedures had been followed. Staff told us that they had only started working once all the necessary checks had been carried out. Checks were renewed every three years so that the manager was able to have updated information about people's suitability to provide care.

## Is the service effective?

### Our findings

Prior to our inspection, we received feedback that whilst many staff were very experienced, some new staff did not have the necessary skills to meet people's needs when they went out on their first visits. A relative told us, "With the young ones, I've had to train a lot of them myself."

New members of staff received a classroom based induction into their caring role which covered topics such as manual handling, health and safety, food hygiene, safeguarding and infection control.

They received a shadow assessment prior to going out on visits on their own. In the files that we looked at, the shadow assessments were usually signed off without comment. We were not shown any examples where these assessments had delayed a care worker going out on their first visits or where gaps were highlighted for future development and training. A care worker told us, "I have had many new carers come out to shadow me and they all say the same 'I don't feel like I have had enough training' or 'I don't feel ready to go out on my own'."

A family member told us the staff caring for their relative with dementia were skilled at supporting them to accept care. Three members of staff told us they had received dementia training and they felt they had the knowledge to meet people's needs in this area. However, staff did not always effectively meet the needs of people with dementia, due to a lack of skills or insufficient time spent supporting the person. A member of staff told us that, "Our dementia training was just watching a film about it. That could be improved – I don't think staff really understand how to speak to people with dementia properly."

A relative told us their family member had health issues which affected their memory, but staff did not always adapt their support to take this into account. They said, "The carers still take [person's] word when they say that the family will do dinner later. They'll rush off without doing dinner as a result. They don't read the care plan." Another relative told us, "My mum's got advanced dementia, they know how to word things to her, to make sure they can get away early." They explained that as a result tasks, such as washing hair, were left undone. A third family member told us, "They're prone to give [person] toast every day for lunch. When I query it, the carer says, 'They like toast.' They do, but when I've got them a treat it's a shame it's not offered, and I have to throw the treat away."

We visited a person with dementia who was expecting a lunchtime call. They told us they were planning to prepare themselves a meal later. Their care plan stated they would forget to eat so even if they declined food, the member of staff was to make them a snack and leave it for them to eat later. We noted on a number of occasions when the person declined food, staff had not provided the person with a meal as outlined in the care plan. For example, one record within the last month read, "(Gave) cup of tea, declined food, says eating shortly."

People told us the more experienced staff were well trained and able to deliver good care. A family member told us staff caring for their relative were skilled in the use of a hoist and staff confirmed they had received training in manual handling and had regular refresher courses. Staff we spoke to were largely positive about

the training they received. For example, one care worker told us, "Its good face-to-face training in a classroom. We get paid to come for training." Staff told us they were supported to develop their skills through further study, for example, a member of staff told us they had completed an NVQ in care in the past.

There were effective systems in place to monitor which courses staff had been on and to make sure their training was up to date. We noted a staff member had been put on a refresher training course when there had been a complaint regarding the quality of their care. When people and families were dissatisfied with the quality of staff support this was not usually linked with lack of skills. More commonly, they told us staff were rushed and did not read care plans or take time to support people with required tasks.

Care staff had regular contact with senior staff. For example, staff told us they received supervision every three months, when they could discuss with their line manager any training needs and any concerns regarding the people they were supporting. We looked at records which confirmed the manager monitored who was being supervised. Staff received spot checks bi-yearly where they were observed to make sure they read the care plans, followed infection control measures and treated people with dignity and respect. A care worker told us a care coordinator had recently carried out an unannounced visit to check on the work they were carrying out. There were also team meetings held regularly. Although staff felt this level of contact was positive, the manager had not effectively used these opportunities to resolve some of the dissatisfaction amongst the staff team.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. We noted that people had signed to consent to care where appropriate. Where people had dementia and could not make a decision staff had guidance about what support needed to be provided. When we spoke to staff they told us they had not had MCA training; however the deputy manager told us this was covered in the dementia training. Despite a lack of knowledge about their legal responsibilities, all the staff we spoke with were able to describe how they supported people with decision-making. For example, staff told us, "We don't give too many choices as people can find this confusing" and "We have been told that our people always have a choice, care cannot be forced on them." People we spoke with confirmed that staff offered them choice, for example one person said, "They gave me cornflakes, I sometimes have egg and bacon. I let them know."

Staff supported people from the risk of poor nutrition and dehydration. However, in addition to our concerns regarding the support with meals for people with dementia, we also received feedback that staff did not have the time to fully support people with eating and drinking. A relative told me, "They heat [person's] meals up, and leave them to eat it, but they struggle and can't feed themselves. They (staff) say they haven't got time to do it."

Other relatives told us that, because visit times were inconsistent, meal times were often too close together. For example, one relative told us that on occasions their family member's lunch and dinner calls had been less than two hours apart. Another person told us, "The office once sent a carer round to do my evening meal at 2pm, fortunately they were switched on and moved things around to come later." When we looked at the daily records during our visits to people we also found there was frequently insufficient time between

a person's visits and meals. For example, one day a care worker left the breakfast visit at 9:53am and arrived for the lunchtime at 11:30am.

People were supported by staff to access health professionals. For example, a staff member had helped a person contact a district nurse when they were concerned they might have a urine infection. A care worker described how they would raise concerns with the office regarding a person if they noticed deterioration in their health, for example a chest infection. Where appropriate they would also ring the GP or family members. People's care plans provided advice regarding needs arising from any health conditions. We saw from the notes that staff had recorded when a person had become ill and a district nurse had been called.

## Is the service caring?

### Our findings

As part of our inspection staff were pro-active about contacting us to discuss their concerns about the service. Overwhelmingly staff communicated a desire to provide a better service to the people they supported. This demonstrated a caring and responsible attitude and a commitment to improve people's quality of life.

A member of staff told us, "Some carers really do care and do all they can to make sure service users are comfortable feel safe and happy. That is not the case for everyone. I have time and time again reported behaviour that is unacceptable." Another care worker told us, "A lot of them (people) are just lonely and the others (care workers) don't sit and chat, they say, "it was an easy call as it was just meds", they stay for 5 minutes." A third carer told us, "A lot of the younger staff don't really know how to talk to older people. They take on extra people on their rounds and then try to rush them" and a fourth member of staff said, "It kills me when I see the way some people are treated by some of the girls."

The feedback we received from people about the service they received was varied, although they were overwhelmingly positive about their usual carer workers. For example a relative told us, "Mostly I would say they're very caring, and do a good job, but some are not very kind." Several people told us that it was difficult to answer questions about their carer workers, because they had so many different staff visit them, and therefore were often not able to build up a rapport with staff. Where people felt their visits had been 'squeezed in' and where staff were rushed there was a high level of dissatisfaction. We were told that in these circumstances the support they received was not caring.

We spoke to a person who had been assessed as needing visits which were 30 minutes long and they described the variation in staff support, "The good staff are respectful, polite and kind...the bad staff are a bit dismissive, they don't really want to do anything, and can be in and out in ten minutes." A relative told us, "It upsets me that [Person] says, 'The carers are always so busy, and have to rush off, I can't ask them anything'."

Some of the carer workers we spoke to were able to describe how they treated people with dignity and promoted their privacy, for example they would use a towel to cover a person when providing personal care. However, people were not always treated with dignity and respect. In particular, we received feedback from three people and their families that staff did not assist them to maintain their dignity as they did not respect people's preferences about what they wanted to wear or how they wanted things done. For example, one person told us, "They don't get me dressed in the way I want. When I go out, everyone else looks pristine and smart, but they put me in creased clothes that don't match. I don't like to say anything." A relative told us, "They stick all the washing in together, so all the lovely underwear is all grey. I've left notes, but nothing changes." Another person told us, "I have to ask them to shower me, or wash my hair. I don't like to because they're so busy."

Relatives told us that when they had raised concerns with staff they were told the person had made the choice not to have support with their appearance. However, in the three examples we looked into, family

members felt staff had not taken time to encourage the people they were caring for. In the three examples, although relatives had raised concerns they told us their family members did not feel able to say anything. One relative said, "[Person] is very private and feels they have lost their dignity, and has to accept whatever staff give them."

Where we had positive feedback, care workers had built up positive stable relationships with people. For example, a relative described the staff, "They're friendly, and kind. They have a laugh with [person], which I really appreciate. It's good to hear that." Other people told us, "The girls are very nice, I get on well with all of them we have a sing-song" and "I'm very satisfied with the girls, they're most respectful and caring towards me. They don't come in and take over, they'll explain what they're doing, and ask permission first."

We were told these care workers knew people well. A relative told us, "They understand (person) very well, they have a chat and a laugh with her. I think they're genuinely very fond of her. (Person) really likes them." When we spoke to care workers about the people they cared for on a regular basis, they spoke about them with great warmth. For example they told us, "I feel that the service users feel safe and happy. When we arrive at their house we will always greet them with a smile" and "(Person) is very positive and loves life."

We observed the interaction between staff and people during our inspection. At one visit, the care workers seemed to know the person well and chatted about upcoming events and about their family. At another visit we observed staff were discreet and calm. They knew the person they were caring for. During the visit we observed them checking with the person before carrying out a task whether they wanted assistance or to carry out the task themselves.

## Is the service responsive?

### Our findings

When we inspected in 2014 we found care plans did not always outline people's needs or give clear guidance to staff on how to support people. At this visit we noted that whilst there were delays in setting up care plans for new people, the manager had implemented changes to improve the quality of the care plans. As part of the improvements the care plans for all existing people who were using the service had been updated and now provided more detailed information to staff.

We looked at a number of care plans and noted these were detailed and personalised, for example there was a short life history for each person. However, it was not always clear for staff to see exactly where information was, which particularly impacted on staff covering for another staff member at short notice. One care worker told us, "Care plans are hard to follow...for example in an emergency I find it very difficult to find basic information in the care plans, including medical history." We discussed this with the manager who agreed to review the wording and layout used in the care plans in the future to ensure staff had access to clear information about people's needs.

The support people received was reviewed every six months, or as required. People and their families, where appropriate, were involved in reviews to find out their opinions on the service and whether there had been any changes in their circumstances. The quality of care plans were also monitored by senior care staff. We saw that where care plans had been audited, care workers had been asked to make necessary amendments where required.

Systems to help staff communicate with each other were not always used effectively, and as a result people did not always receive continuity of care. Managers were also not able to monitor care was being provided in line with people's support plans. During one of our visits we noted there were no records completed prior to the day of our inspection. At another visit, there were no blank record sheets so for the previous month staff had recorded the care provided in margins and on any available space, making it very difficult to see when they had visited. A member of staff told us, "Other staff don't always fill in care plans properly. What does, 'All care given' mean? It doesn't explain anything, and it doesn't tell anything to the next staff who visit." Another staff care worker described the same issue but said that they had raised a concern about the poor recording and all staff had been contacted by the manager, after which there had been an improvement in recording.

Prior to our visit, we sent a questionnaire to people who used the service, and to their families. One of the greatest reasons for dissatisfaction was in the area of timekeeping. We were told by the manager that where calls were time critical, for example where a person had an appointment then rotas were planned to accommodate this. However, people told us even if their calls had not been assessed as time critical, the inconsistent timekeeping caused frustration and inconvenience. For example, a family member said, "Sometime the carers don't turn up when they should do, which means I can't go to my club as I can't leave (person) on their own."

Timings of visits did not always meet people's personal needs and circumstances. People explained that

overall where they had regular carers they kept them informed about changes in visit times and one person told us they had complained to the manager so the timings of visits had improved. However, the remaining people who had raised concerns in this area told us they felt they had no choice but to accept the service on offer. For example, a person told us, "Timings are a problem; they're not properly spaced out – if you complain the attitude is "You'll have to put up with it, or you won't get a call."

A professional told us the person they worked with often had to go to bed too early and times of visits did not meet their personal preferences. We were told, "[Person] wants to go to bed at 9pm but sometimes the evening call is 6.30pm because carers want to finish early and don't want to be out until ten at night." Other people and families told us how the timings of visits impacted their lives. One relative told us they had to spend time ringing the office to find out where carers were, which they found frustrating. Four people told us of difficulties with hospital appointments and cancelled social events due to staff arriving late or rotas not being changed to fit in with changed circumstances.

There was a conflict between the expectations of people being referred to the service and the systems in place to ensure referrals took place swiftly. The manager gave us an example where they had told hospital staff the only available morning slot available was a 10 o'clock visit. Despite a person requesting an earlier visit they had been discharged home, leaving the agency to manage their dissatisfaction. The manager told us this was something they were trying to avoid in the future, through improved communication with health and social care staff. Staff described how they tried to move their visits around to accommodate people. For example, a member of staff told us, "New clients get added in any time, but I ask them, 'Is this time alright for you?' If not I'll try to rearrange them."

Three people told us the service did not always accommodate request for male or female care workers. For example, a relative told us their family member was scared of male care workers in the evening visits and when this was raised with the office staff, the relative was told staff couldn't guarantee not to send a man again. Another person told us they had requested female only carers. They told us, "I don't want male carers, I have told them. I had one very recently, he was very nice actually...but I'd rather not have them." They told us they had not complained about it, as they did not feel able to make a fuss. People who responded to the questionnaire we sent out were unhappy new or replacement carers hadn't been introduced to them before they provided care. When we spoke to people about visits from male carers, we were told the main anxiety and fear was caused because male carers had visited without being introduced first.

The care people received did not always meet their needs and reflect their preferences. This was a breach of Regulation 9(1)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

Written, formal complaints were logged and we noted that people and their families received a personalised response from the registered manager or deputy manager. A person showed us the complaints policy in their care folder. There was less satisfaction with how the service managed informal complaints. A member of staff told us concerns were dealt with by senior staff but they added, "I don't give up; I keep ringing until they sort it. I know why clients give up; it's not fair on them." A family member told us, "I've only once had a call back from senior management about a concern, but I had to make a real fuss to get that. Normally nobody rings back." They told us, "If you make a complaint, things might improve for a week or two, but nothing major changes and it goes back to how it was again."

We told the manager about the negative feedback we had received when we spoke to people and families on the phone. The manager told us their staff also rang people asking them about the quality of the service and feedback from these calls was largely positive. Some people told us they did not feel comfortable raising concerns and others said they did not feel confident changes would happen. As a result, some of the

concerns we had found were not being captured by the telephone calls being carried out by the provider and improvements were not being made in response.

## Is the service well-led?

### Our findings

The manager had responded positively to the feedback they had received at our last inspection. We saw, for example, that improvements to care plans had been made following quality checks from senior members of staff. The registered manager also demonstrated a commitment to addressing the concerns we raised during this inspection.

The manager told us there were systems in place to ensure they had a good oversight of the service, for example there were detailed logs of calls which took place outside of office hours. The registered manager provided data on a weekly basis to the provider. This included information such as whether reviews of people's care packages had taken place and staff turnover. The provider also carried out an annual quality audit.

These quality auditing processes had not picked up, however, many of the concerns we found in our inspection. These included late calls, delays in providing support plans for new people and poor recording by staff. As a result, risk was not minimised and improvements in the quality of the service were not implemented. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall feedback we had from people was that although regular carer workers were of a good standard, the rota system was not well organised, did not offer choice and caused inconvenience and anxiety. We were told when people and families tried to communicate their concerns the manager was not accessible and visible. People said they did not know if this was because their messages were not put through or the manager was too busy to deal with their queries. For example, one person told us, "I spoke to someone in the office, who wouldn't put me through to the manager" and a second person told us, "You can never speak to the manager or senior staff – that's where the problem is." A relative told us, "I waited four days for the manager to ring me back. When I rang again [Manager] said they had not received the message."

Whilst many of the systems in place worked well there was pressure throughout the service resulting from the number of referrals. The organisation was one of the largest care agencies in the local area and had a key role in picking up emergency placements, for example when people were being discharged from hospital. Many of the concerns we found related to the pressure on staff and managers to accommodate new referrals, during a time where recruiting and retaining staff was a challenge. In addition, we were told there had been significant staffing changes, which had included the departure of a number of senior and front line staff. Many of the staff we spoke to said they were unsettled by the changes and by the increased pressure on the remaining staff.

Some staff told us they were very enthusiastic about their role. For example, one staff member told us, "I like the job, the office girls will help you as best they can, they are fair and honest. To me they have the service-users best interests at heart". The main reason for dissatisfaction amongst care workers was communication with the office and the requests to fit more visits into to an already full schedule. A care worker told us, "Staff are leaving because of the texts and calls asking people to come in in, even during our holidays." Another

care worker told us they felt guilty when they received texts which said that unless they accepted shifts, people would be left vulnerable.

Staff told us that the manager addressed poor practice. A member of staff told us, "People have been sacked during their probationary period, because they were lazy. Management do take it seriously." However, two care workers told us the pressure on staffing meant care coordinators and other members of the management team did not always feel they could challenge poor practice. One of the workers said, "Yes, there is an open door policy but I'm not sure if things change because they are under such pressure."

The team did not always work smoothly together. For example, staff said they felt able to raise concerns; however they frequently mentioned they would only speak to a chosen senior member of staff. A staff member told us, "I feel supported by senior care staff. I don't have a lot of dealings with the manager to be honest." We were told by staff they were not always able speak to the manager and did not feel their concerns were consistently escalated upwards. One care worker told us, "[Senior workers] try to divert me away from speaking to the manager ... The manager is actually extremely nice, and has been very helpful to me. The problem is you have to fight to get to her in the first place."

Despite feedback from some staff that the manager was not always visible, we noted they used a variety of methods to keep in touch with staff such as team meetings, emails and a regular publication called Grapevine. We looked some issues of Grapevine and saw this was used to try and improve staff morale, such as thanking them where things were done well. It was also used to communicate areas of concern. We noted the manager had highlighted the timings of calls and missed calls, which were two concerns we had picked up during our inspection. Team meetings were arranged twice a year for care staff. The manager had responded to poor attendance and these were now held across geographical areas to make it easier for staff to attend.

Measures were in place to capture people's views about the service. Several people told us they received regular questionnaires asking for their feedback, however responses varied about their effectiveness. A person told us, "I get fed-up filling them in; I think they come every other month. What's the point if nothing changes?" Despite this feedback, we saw a letter which had been sent to advise people on the outcome of a survey about the quality of the service. The letter outlined improvements being put in place to address any concerns from the feedback, for example letting people know revised typed care plans were going to be put in people's homes. We noted that the changes outlined in the letter were being introduced.

The manager was committed to addressing the pressures and concerns which we had found during our recent visit and some improvements were already underway when we arrived. For example, a new role had been set up to process referral paperwork around new packages of care. We looked at the notes from the team meetings and saw the manager had raised with staff many of the concerns we had found during our visit, such as concerns regarding missed visits. The manager told us they had been working more closely with the local authority to improve the safety and quality of people's discharge home from hospital. The manager told us they recognised the importance of recruiting new staff to enable the organisation to manage the level of demand for its services.

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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>Care was not always provided in line with people's needs and preferences.</p>
Regulated activity	Regulation
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The registered manager had failed to assess in a timely manner the risks to the health and safety of service users and had not consistently put in place measures to mitigate any risks. This was a breach of Regulation 12(1) (2)(b) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Quality auditing processes did not pick up many of the concerns we found in our inspection. These included late calls, delays in providing support plans for new people and poor recording by staff. As a result, risk was not minimised and improvements in the quality of the service were not implemented. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation

There were not enough staff deployed to minimise risk and meet the needs of people receiving care from the service. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.