Teonfa Limited

Teonfa care services

Inspection report

Suite 7Gi, Britannia House
Leagrave Road
Luton
Bedfordshire
LU3 1RJ

Tel: 01582730591

Date of inspection visit:
01 March 2017
02 March 2017
03 March 2017
07 March 2017
09 March 2017
10 March 2017

Date of publication:
18 October 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on the 1, 2, 3, 7, 9 and 10 March 2017 and was announced. We last carried out a comprehensive inspection of the service in March 2016 and it was rated "requires improvement" overall. We carried out a focused inspection in the domains of 'safe' and 'well-led' in August 2016 but found that insufficient improvement had been made, and the rating remained 'requires improvement'. We identified concerns in relation to people's visit times, the management of medicines, staff recruitment, monitoring of care delivery and training to understand the Mental Capacity Act.

This inspection identified further serious issues regarding the management and leadership of the service and the quality of their care delivery. The feedback from people and staff regarding the quality of the care and support was poor and showed that changes were not being implemented or embedded within acceptable timescales.

Teonfa Care Services is a domiciliary care service providing personal care and support to people in their own homes. At the time of our inspection, the service was providing care to 62 people.

The service had a registered manager, although they had applied to de-register from their role. 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.

People did not always receive their calls on time, and many people reported missed calls or calls frequently cut shorter than the allocated time. This meant that people were placed at risk of neglect, missed medicines and not having their healthcare needs attended to within a reasonable time. The service did not have a system for monitoring their calls and identifying persistent issues that required improvement.

People had care plans in place but these were varied in quality and lacked sufficiently up-to-date, relevant and personalised information to enable staff to carry out their care effectively. There were concerns in relation to people having consented to the care provided and people's capacity to make and understand decisions about their care was not always assessed. People were asked for their views through surveys and quality monitoring calls but issues identified were not always resolved. People's needs in relation to health and nutrition were assessed but erratic call times meant these needs were not always being met.

People had mixed views as to whether they felt cared for and were treated with dignity and respect. People received good care from staff who were regular and understood their needs but there were concerns in relation to the aptitude and consistency of less regular staff.

There were not always enough staff to fulfil the number of hours of care commissioned by the agency. Rotas did not always account for adequate travel time between calls and staff were not deployed in a way that

enabled them to get to people on time or remain for the scheduled duration of the call. Staff received basic training in medicines and moving and handling, but the service had accepted care packages for people with more specialised needs. The staff had not been trained in how to meet these needs. Staff did not receive training to understand the Mental Capacity Act (2005). Staff recruited to the service did not always have suitable references in place, and there were gaps in employment histories which had not been accounted for.

People did not always feel confident that complaints would be resolved, and expressed concerns that the management were not always responsive. There were missing or incomplete records, and the systems in place to identify this were ineffective. People's call times, medicines, rotas and care plans were not always available or complete.

Staff received regular supervision and appraisal and were subject to a full induction when they joined. The staff were positive about the culture of the provider and felt supported and listened to by management. They were able to contribute to the development of the service through team meetings.

This inspection identified that there had been breaches of a number of the regulations of the Health and Social Care Act 2008 (Regulated Activities) 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

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.

People did not always receive care on time, and calls were frequently late, shortened or missed.

Risk assessments were not always completed and appropriate action taken to mitigate people's exposure to the risk of harm.

People's medicines were not always accounted for correctly.

There were not enough staff deployed to provide care for the number of commissioned care hours.

Recruitment checks were not always completed to ensure a robust recruitment process was in place.

Is the service effective?

Inadequate

The service was not effective.

Staff did not receive training to understand the requirements of the Mental Capacity Act (2005).

Staff completed basic training but were not sufficiently trained to understand the range of complex needs of people using the service.

The service did not always seek consent for the care provided.

The service did not ensure that people had their meals and drinks available when they wanted them.

Is the service caring?

Requires Improvement

The service was not always caring.

People received good care from their regular staff but inconsistency in call times and staff ability meant that they did not always feel well cared for.

Some people were not treated with dignity and respect.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were not in place within a reasonable time of a care package being started.

Care plans contained contradictory, misleading and inaccurate information in relation to the times of people's care calls.

Complaints were not handled effectively and the provider did not adequately respond to people's concerns.

Is the service well-led?

Inadequate

The service was not well-led.

There was insufficient governance and oversight of care delivery which meant that people were left at continued risk of failing to receive adequate care.

Records were often unavailable, inaccurate or contradictory.

People were not confident that they would always receive a response from the office when they raised concerns.

Staff felt well supported by management and able to contribute to the development of the service.

Teonfa care services

Detailed findings

Background to this inspection

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

This inspection took place 1, 2, 3, 7, 9 and 10 March 2017 and was announced. The provider was given 24 hours' notice of our inspection because they run a domiciliary care agency and we needed to ensure that somebody would be available in their offices to meet with us. The inspection team was made up of two inspectors who visited the provider's office on the 1 and 7 March 2017 and made calls to people using the service on the 9 and 10 March 2017. An Expert by Experience made calls to people on the 9 and 10 March 2017. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information available to us about the service such as that received from the local authority, public and staff. We reviewed the information provided to us by the provider including notifications and the provider's action plan from the last inspection. A notification is information about important events which the provider is required to send us by law.

During our inspection we spoke with six members of the care staff, the field care co-ordinator, the care manager, registered manager and director. We contacted 19 people who were using the service and 17 of their relatives by telephone to ask for their views on the care they received. We reviewed the care records and risk assessments of 15 people who used the service, checked medicines administration records, daily records and reviewed how complaints were managed. We also looked at six staff records and the training for all the staff employed by the service. We reviewed information on how the quality of the service was monitored and managed.

Inadequate

Is the service safe?

Our findings

During our last comprehensive inspection in March 2016 we identified issues with recruitment procedures, call times and the management of people's medicines. During a focused inspection in August 2016 we found that improvements had been made to recruitment and medicines management but that people continued to receive late, missed or shortened calls. During this inspection we found that insufficient improvement had been made and found other significant issues in relation to people's safety.

We received mixed responses when we asked if people felt safe. One person using the service said, "It was a bit risky at the start. Most of my calls weren't happening, and I had hours which were supposed to be provided which they weren't able to deliver care for." Another person said, "No, I don't feel safe. Far from safe. I couldn't wait for them to get out of the door." A relative said, "No, we have raised a number of issues about the safety of the care they are providing." However others said they had no concerns in relation to safety. One person said, "Yes I do feel safe." A relative said, "Safe- absolutely, yes. Both [staff] are very supportive."

Several of the people and relatives we spoke with were able to illustrate the impact of not receiving calls, or receiving calls at times that were unsuitable to meet their needs. One person said, "You can't say what time they're going to be there and two or three times they haven't turned up at all. They are regularly late, sometimes a half hour and sometimes an hour but I'm waiting to have something to eat." A relative said, "We've had problems with carers not turning up or coming late in the past. There's been loads of occasions where nobody's turned up because there were no staff if [their relative's] regular carer wasn't available." Another relative said, "The main bugbear we have is with erratic timekeeping. The tea calls [relative] have are supposed to take place at 4pm but have been as much as two hours late. We held a review meeting with the local authority last year and it was agreed that they could contact us if calls were going to be 20 minutes or more late, but they haven't. We have to be aware of when calls are because [person]'s medicines are time critical."

Calls were frequently cut short and daily notes showed that staff rarely stayed for the correct amount of time with people. One person said, "Some carers do stay for the right amount of time but sometimes they'll try and leave early and I'll have to remind them that they're supposed to be there for the whole duration." A relative said, "They don't generally stay for the complete time, sometimes they'll leave in under half the time they're supposed to be there." Another relative said, "They never, ever stay for the correct amount of time. They don't seem to bother to carry out all their duties and if it's a half hour call [relative] is lucky if they stay for 10 minutes."

Calls which were supposed to last half an hour were frequently cut to fifteen minutes or less. We noted that one person was assessed as needing two calls each week to last one hour and 45 minutes. When we reviewed their care notes we found that these calls had been recorded as 10 and 12 minutes on two occasions. While we saw some evidence that reviews were requested for people who did not require all the time allocated for their calls, the ineffective monitoring of these meant that the short calls were not being identified or monitored. We spoke to 19 people and 17 of their relatives. Seventeen of them told us they had

experienced missed calls since receiving care from the agency, whilst 24 raised concerns with persistent lateness.

The service had a policy for missed and late calls which established that any call over 15 minutes late would be classed as "late" and would be recorded with details and reasons for delays. The policy went on to state that missed calls would be records with times, reasons and arrangements made. However the provider was not following their policy in recording these or reporting them as required. We were shown an example of when a missed call had occurred and had been recorded in accordance with the provider's policy. However, this was from 2014. The policy on late and missed calls had not been reviewed since 2012.

When we asked people and their relatives if there were enough staff, many responded that they felt the service was "short-staffed". A relative said, "I definitely don't think there's enough staff. The rotas aren't put together correctly so sometimes two carers need transporting together and one just sits outside." Another relative said, "They don't have enough staff to fulfil [person]'s needs or they wouldn't be leaving early." A third relative said, "It's the pressure on [staff]'s time - that's why they leave lights on or the door unlocked. They're too rushed to check things."

The service employed 23 people including the office staff, who were regularly required to attend calls. This meant that records or administrative work that needed to be completed was delayed because the office staff were required to work in the field. Rotas showed a high turnover of staff and many staff working long days over extended periods. Twelve people required two carer workers on each call and 10 of these had four calls a day. The rotas we looked at were incomplete so we could not always determine which staff had completed each call.

The service was commissioned to deliver 812 hours of a support a week. This would have required each member of the care staff to work a 40 hour week with no allowance for holidays or sickness. With deployment across diverse geographical locations, a number of non-drivers and staff working on zero-hour contracts, the service could not consistently deploy enough staff to fulfil people's needs. There was no system in place for assessing staff availability and commissions were accepted without consideration as to whether adequate resources were available to meet people's needs. This put people at risk of failing to receive care on time. The provider told us they were planning to implement a more robust assessment system and had stopped accepting new care packages in the weeks prior to our inspection. They made a further commitment to continue this until May 2017.

The failure to ensure that there was enough staff to meet people's needs was a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that late or missed calls had an impact upon their ability to have their medicines administered on time. One person said, "There's been times where they haven't turned up for calls. It has a massive impact because I'm meant to [go out] and if they're late it means I can't take my medicines. Because of [condition] the calls are crucial." Another person said, "They get the medicines all muddled up. I should have [medicine] every Monday and only one [staff] remembers. They sometimes come so late they forget. I can't blame them: they're pushed."

A relative said, "We've had one occasion where nobody turned up for a call. The timings are really important because [person] is diabetic and needs insulin. I tried calling the office, tried calling the emergency number. But it's happened again since. [Person] has medicines to prevent them from having a stroke. The district nurses come to give [person] insulin but she was still in bed having not eaten anything, taken any medicines or been washed." A third relative said, "We had a lot of problems with staff not coming round and [person]

needed medication for [condition] and [person] couldn't have it if people didn't turn up. It was shocking to start with so I complained to the council. [Person] has been out of hospital. I was worried about my [relative]'s health."

One person's medicine administration record (MAR) charts for January 2017 showed completion on only five days. Missed medication on the 21 January 2017 resulted in them having a seizure and being admitted to hospital. Despite this there were several days on MAR charts for the following month in February that did not show that the medicines had been administered. The daily notes were incomplete and did not show whether the medicines had been administered. This demonstrated that the service was failing to learn from previous errors and failed to protect people from the risk of missing their medicines. In January 2017 a safeguarding was raised because a service user was found 'wandering the streets' having not had their medicines which were critical for their cognition. The person reported that their calls were frequently missed or late. On inspection, there were significant gaps in their MAR charts and daily notes. The last MAR chart available to us was from November 2016.We were therefore unable to inspect subsequent records and the service could not evidence the action taken in response to this incident to prevent the risk of recurrence.

The failure to manage people's medicines safely was a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The failure to keep accurate records in respect of people's medicines was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We identified fresh concerns in the recruitment and employment of staff. References were not always validated or sought from previous employers to ensure that staff were suitable for the roles to which they had applied. Some references were not appropriate, for example one member of staff had a reference from a family member. Gaps in employment history were not always adequately explored during interviews and some staff had not stated their reasons for leaving their previous employment. Character references had been accepted although prospective staff had recent employment dates listed in their applications. This was contrary to the registered manager telling us in their action plan that "More robust internal processes have been put in place in order for a second personnel to check that the file is compliant prior to the applicant commencing employment." This left people at risk of receiving care from staff who may have been unsuitable.

The failure of the provider to follow their action plan to ensure that staff recruitment processes were robust was a breach of Regulation 19 of the Health and Social Care Act.

Risk assessments were completed to identify any risk to people or staff, with control measures identified to mitigate these. This included identifying risks to the environment and risks associated with moving and handling. Risk assessments were usually completed at the time of assessment but were not always updated as people's needs changed. We asked to see accident and incident forms to see how the service were responding to any incidents that occurred, however none had been logged since 2015. While some incidents were recorded in care notes, they did not include information on how the incident would be followed-up and resolved or how to reduce the risk of recurrence in future.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff we spoke with were aware of how to raise safeguarding issues and who to contact if they had any concerns in relation to people's safety. The provider had a whistleblowing policy in place to enable staff to

report concerns anonymously without fear of the consequences of doing so.

Inadequate

Is the service effective?

Our findings

During our last comprehensive inspection in March 2016 we identified issues with staff supervision and lack of training to help staff to understand the Mental Capacity Act (2005). During this inspection we found that while some improvements had been made, the service was still failing to provide consistently effective care.

We received mixed feedback when we asked whether people felt that staff had the right level of training to enable them to carry out their duties effectively. One person said, "Some staff don't have the understanding of [condition] so I think they need to brush up on that. They need to have some training." Another person said, "How they say some of them are trained I don't know. Some of them are very young and inexperienced." A relative told us, "No, they're not skilled. None of them." Another relative said, "I believe they go on courses and do NVQs. Some are more caring than others." A third relative said, "The staff that come do seem well trained. They understand [relative]'s needs and seem to do what [they] require now that [they] have regular staff."

The staff we spoke with felt they had enough training to enable them to carry out their duties effectively. One member of staff said, "We'll always have more training if [provider] feels we need it, but I think the staff are all pretty competent and experienced." Staff received training that the provider considered essential when they commenced their employment with the service. This including training on medication and moving and handling. We saw in staff files individual records to indicate that this training had been completed. However the training matrix was not up to date and there was no clear monitoring of training needs and the dates staff had completed training modules. The service had accepted care packages for people with a variety of complex needs including learning disabilities, diabetes and epilepsy but did not provide any specialised training to enable staff to develop a better understanding of these conditions or how to support people living with them. A relative described the impact of this and said, "When [person] has a fit they will call me because they don't know what to do."

Failing to provide adequate training to enable staff to provide effective support was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service still did not provide training for staff to understand the Mental Capacity Act (2005). 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Applications for people who live in their own homes must be made to the Court of Protection. There was limited or absent information in people's care plans relating to their capacity to make or understand their own decisions., Because staff had not received training to understand the principles of the MCA it meant that they were not aware of how people's capacity

could be determined. This was raised in the previous comprehensive inspection but had not been resolved.

While some people told us they consented to the care being delivered, we were informed of several issues relating to consent. One person told us that they had felt "pressured" into signing a care plan despite not being happy with the contents. A relative said, "There have been times where we've informed the office that [person] won't be at home but staff have still entered their house and signed their notes without consent." Another relative told us, "We had an issue when [relative] started [to receive care] because I wasn't consulted when they went and visited [relative] in hospital to establish a care plan even though [they] don't have full capacity. I wasn't consulted until later on." Five of the care plans we looked at had not been signed to indicate the person's consent to the care had been given. This meant that we could not be assured that people had agreed to the contents of their care plan, were happy for the support to be provided or that consent had been obtained in a way that was lawful and protected people's rights..

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's healthcare needs and conditions were listed in their care plans, including any additional support they needed or any involvement from other healthcare professionals. However not all people's conditions were included in their care plans. One person who had an allergy to a specific type of material did not have this included in their care plan. The provider had not supplied staff with the correct equipment to be able to provide care safely to the person. This put them at risk of harm.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Another person told us, "The other day they left [person]'s bed in an upright position and [they] were right up in the air- it's good that we came to see [them]. [They] were very, very uncomfortable." In response to this, the provider told us they were confident that staff always asked people if they were comfortable before leaving.

People's dietary needs were detailed in their care plans along with some information about their likes and dislikes and the support they needed with eating. Some people we spoke with told us they received their meals in good time. Other people raised concerns about the inconsistency of calls and the impact this had upon their meals. One person said, "At my age there's things I can't do. They are supposed to get my meals so if they don't turn up I can't always eat."

The staff we spoke with told us they received regular supervisions and appraisals. One member of staff said, "We're supervised regularly at the office but also have spot checks when we're working in the community. We're given feedback on our performance, told about updates and areas for improvement." Staff records confirmed that supervisions and appraisals had been completed regularly and that staff were being monitored during visits to provide feedback on their performance.

Requires Improvement

Is the service caring?

Our findings

Most of the people and relatives we spoke with told us that their regular care staff were kind, compassionate and treated them with respect. However the shortcomings of the service in terms of visit times, management and deployment of staff had an impact on the overall quality of care being provided.

One person said, "They seem to be doing a good job so far and they seem lovely, the heart is in the right place." Another person said, "One of the [staff] really makes me laugh." A relative said, "The staff are nice, and [relative] finds them approachable and likes them all." Another relative said, "The [staff member] who came this morning knew it was our anniversary and helped me to put on my suit for tomorrow. I'm really grateful."

However others expressed concerns that inconsistency in care staff and visit times meant that they did not feel they were always receiving good care. One person said, "I have to tell them silly things like where things are kept and remind them of what they're doing because I was getting eight or nine different care staff a week. They're getting away with murder because I don't have [staff] who know me so they spend most of their time trying to work out how to actually care for me." Another person said, "They [staff] are not regular. I had a carer and I didn't trust them a bit." A third person said, "Twice they didn't turn up, but now they do. Some carers get upset if they're late and they're working seven days a week. Some are in and out like a bullet. I've spoken to the office because [staff] is supposed to do 15 minutes but does nowhere near that. Not even 10 minutes. We just want a few minutes more and to be asked if we want a drink. [Staff member] leaves the bottle empty."

We received mixed responses when we asked whether people felt they were treated with dignity and respect. A relative said, "The carers are kind, respectful and my [relative]'s dignity is always upheld." However other raised concerns about the approach and attitude of staff. A relative said, "Some carers would let themselves into the house and wouldn't even speak to [relative], they would walk in, leave their coats on and try and get it done as quickly as they can." Another relative said, "I visited once and the carer was just having their lunch and studying. They made no effort at all to do anything with [person]. They let [them] just sit in front of the television all day when the sun is out. They don't care. They don't wash, feed or interact with [person]."

The staff we spoke with told us they enjoyed working with the regular people they saw and received information via messaging apps and in people's care plans when providing care for the first time. One member of staff said, "I love being with the clients and it's nice knowing we can make a difference." Another member of staff said, "I love seeing [person] and I know I make their day when I go in." Staff were able to describe how they respected people's dignity and privacy while providing care. One member of staff said, "I make sure curtains are closed, doors are shut and that I speak to people respectfully to let them know what I'm doing."

Inadequate

Is the service responsive?

Our findings

During our last comprehensive inspection in March 2016 we found that care plans were not always detailed or personalised enough to enable staff to provide consistent, person-centred care. During this inspection we found that while some improvements had been made, the service was failing to provide consistently responsive care.

We received mixed responses when we asked if people were involved with the creation of their care plan. One relative said, "We were consulted on the contents of [person]'s care plan and we had meetings with the manager and [provider]." However another relative told us, "We didn't have a care plan originally and it took a while to receive one that had the right information in for [relative]." A third relative said, "There was no care plan put in place for six weeks when they started providing [care] to relative. [They] can't always get a response from [relative] so they were just having to make it up during each visit." The provider informed us they would always aim to have a care plan in place prior to support commencing, but if not would provide staff with enough information using the assessment to be able to carry out the required care.

There was a variance in quality in the care plans we looked at. While some demonstrated evidence of improvement in terms of detail and personalisation, others were still limited in detail. Assessments were carried out prior to the delivery of care to establish the person's needs and create a care plan. Care plans included sections such as communication, mobility, personal care and medicines. A list of tasks to be completed on each visit was included to enable staff to understand how to provide the person's care. We saw that care plans included outcomes such as "I would like to remain clean and presentable in my own home at all times" and "I would like to remain independent." While these provided staff with goals to support people towards, they were generic in nature and often repeated across multiple care plans. The care plan within one person's records described them by the wrong name and gender. Therefore, we could not be certain, that the information within the plan related to the person whose file it was in. This could have led to inappropriate care being provided.

Information in people's care plans was also inconsistent in relation to the times they were due to receive their calls. There was often little correlation between the times listed in care plans, the times allocated on rotas and those recorded in daily logs. For example one person's morning call was recorded as being 7 o'clock in one part of their plan and 8 o'clock in another. However they were frequently receiving care at 9 o'clock and rotas showed a call scheduled as late as 10:15. The service did not have a system to monitor the times that staff logged in and out of their calls, so were not always able to be responsive to missed or late calls. The inconsistency in call times was highlighted at our previous inspection but no improvement had been made to rectify this.

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

Some of the people and relatives we spoke with told us that they did not have confidence in the way that the provider handled complaints. One person said, "If you ring them at the office they don't ring me back. What

can I do? No point ringing them." One relative said, "They seem to just put complaints back onto the staff or blame the people." Another relative told us, "I've raised issues with the office but I'm not notified of any outcomes. I've written to them with evidence but then I was told that it wasn't their fault and given excuses."

We looked at the complaints received since our previous inspection but found that not all of the complaints raised by people had been recorded. Those that had been received were not always investigated or resolved effectively. A response and outcome was not present in any of the complaints we looked at. One person had complained about not receiving their calls despite requiring their medicines to help manage their condition. The provider had written that the service was 'short-staffed' without accounting for the reasons why, the impact, or how they would reduce the risk of this happening again. The response had not been communicated to the complainant. The defensive tone in the complaint investigations did not promote learning or accountability, and put people at risk of having their concerns disregarded.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

During our last comprehensive inspection in March 2016 we identified concerns in relation to the way that medicines were accounted for and how the service managed rotas. A further focused inspection in August 2016 found further shortcomings in the monitoring of visits and the responsiveness of management. During this inspection we identified further issues in relation to the overall management, leadership and governance of the service.

There was a registered manager in post who remained active at the service, although they had applied to de-register at the time of our inspection. We therefore spoke with the manager who had been appointed two months previously and was going to apply to register with the Commission. We also spoke with the provider who was involved in the day-to-day running of the service. However following the first day of our inspection we were told that the new manager had resigned and that the provider would now apply to become the registered manager. We noted that there had been a significant turnover in office staff since our last focused inspection and that many staff were new to their roles. We found that the inconsistency and uncertainty generated by these changes had meant that required improvements had not been made.

Since our last inspection in August 2016 the service had accepted an additional 24 care packages and the provider was in the process of registering an additional location in another area. Prior to our inspection a voluntary freeze was placed on accepting further care packages. However the failure to make sustained improvements or act upon concerns raised in previous reports indicated that the growth of the business had been prioritised above improvements in the quality of care delivery. Contracts to provide care were accepted without proper consideration as to whether the service had the capacity or the ability to provide the care people needed.

Some people told us they knew who the managers were and felt they were approachable and responsive. One person said, "I've seen a few managers and all of them have been lovely." A relative said, "The [managers] are approachable and they did listen to me when I raised issues." However others raised concerns about the responsiveness of management and felt they were not listened to. A relative said, "I've tried ringing the office and the emergency line and you don't always get an answer. Communication seems to be a weakness in terms of the office staff and sometimes they're not adhering to their own protocols and procedures." Another relative said, "Communication is poor. Trying to get hold of the office is a problem and we're not told when they're running late or given any kind of response at all sometimes." A third relative said, "We were told by the manager not to complain to social services because they were worried that it would impact on their reputation."

There was still no system in place for effectively monitoring visit times. We were shown a demonstration of a new system sourced by the provider which would enable staff to 'check in' during each visit so that they could be accounted for electronically. However there had been issues implementing the system and it was not being used at the time of our inspection. The service had grown significantly since the previous inspection but the systems in place remained unsuitable for monitoring the effectiveness of care being delivered.

There was no straightforward method for the service to demonstrate to us the number of late, missed or 'clipped' calls and the action being taken in response to these. Care notes were returned to the office and audited. During our last inspection we were told this would occur on a monthly basis. However we found that this remained sporadic, and that audits were not always effective in identifying ways to improve on the issues identified. One person had 47 visits unaccounted for between November and January, including seven entire days. The audit had identified this but did not include any information as to how this was addressed. Another person had commenced care with the agency in August 2016 but no care notes had been returned for review. Others were still outstanding at the time of our inspection and some information wasn't available to us or the provider. This meant that the service could not effectively monitor the quality of care that people were receiving, and left people at continued risk of late or missed visits.

Audits of MAR charts were being carried out sporadically although several MAR charts were not available to us during the inspection. The audits were sufficient for identifying gaps or errors but these were not fully accounted for or explained. The remedial actions listed were usually recorded as "spoke to staff", which did not evidence to us that the service were taking proper account of whether people may have missed their medicines or whether these were errors in recording. Similar audits were carried out on care notes, but several of these were also missing, had significant gaps or had not been audited. One person whose care commenced in August 2016 had no care notes or MAR charts returned to the office for auditing. This meant the service could not identify or address any errors, omissions or changes.

The failure of the service to develop effective systems for monitoring the delivery of care was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff we spoke with were positive about the support they received from the management staff. One member of staff said, "The managers are very helpful and supportive. I think they really do care about the [people]." Another member of staff was positive about the values of the organisation and said, "I like the heart of the company and I think we follow our values to make sure that [people] are treated well."

Staff told us they were able to contribute to the development of the service through regular meetings. One member of staff said, "We have regular staff meetings and then management meetings. We'll discuss any difficulties we're having, including difficulties at weekends or with individual [people]." We looked at the staff meeting minutes for November and January and saw that these had included discussions of visit times, training and individual people. Weekly meetings had been taking place and we saw that some issues had been discussed including shortened visits, communication issues and updates.

The provider sent surveys to people using the service and these had been completed in July 2016. We noted that people's feedback in relation to the care received was generally positive, but that several people had raised issues around punctuality and training of staff. One person said they felt unsafe while they were receiving care and another three people raised concerns around late calls. These concerns had not been followed up directly so we could not ascertain how the service had responded or resolved the issues. The provider told us that they were planning to send out a new wave of surveys shortly after our inspection.

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 9 HSCA RA Regulations 2014 Person-centred care People did not always have up-to-date, accurate and person-centred care plans in place to enable staff to provide consistent care and support.

The enforcement action we took:

We placed conditions on the provider's registration to restrict further care packages without written consent from the Care Quality Commission, to ensure the provider put systems in place to manage care calls effectively, and to produce a monthly report to the commission on action taken to improve the quality of the service.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not always sought or accounted for in the delivery of care.

The enforcement action we took:

We placed conditions on the provider's registration to restrict further care packages without written consent from the Care Quality Commission, to ensure the provider put systems in place to manage care calls effectively, and to produce a monthly report to the commission on action taken to improve the quality of the service.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not always being managed or accounted for correctly.

The enforcement action we took:

We placed conditions on the provider's registration to restrict further care packages without written consent from the Care Quality Commission, to ensure the provider put systems in place to manage care calls effectively, and to produce a monthly report to the commission on action taken to improve the quality of the service.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving

	and acting on complaints The provider did not have a robust system for handling complaints and was not always able to evidence how they had been resolved.

The enforcement action we took:

We placed conditions on the provider's registration to restrict further care packages without written consent from the Care Quality Commission, to ensure the provider put systems in place to manage care calls effectively, and to produce a monthly report to the commission on action taken to improve the quality of the service.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not keep accurate records to account for the delivery of people's care. There were ineffective systems in place for monitoring care and identifying improvements that needed to be made.

The enforcement action we took:

We placed conditions on the provider's registration to restrict further care packages without written consent from the Care Quality Commission, to ensure the provider put systems in place to manage care calls effectively, and to produce a monthly report to the commission on action taken to improve the quality of the service.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient numbers of staff deployed to ensure that people received their care on time.

The enforcement action we took:

We placed conditions on the provider's registration to restrict further care packages without written consent from the Care Quality Commission, to ensure the provider put systems in place to manage care calls effectively, and to produce a monthly report to the commission on action taken to improve the quality of the service.