Zion Domicillary Care Limited

Zion Domiciliary Care Hampshire

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We conducted this announced inspection on 19 and 20 November 2015, 2, 3, 8 and 9 December 2015, in response to concerns that had been raised regarding the quality of care being provided by Zion Domiciliary Care Hampshire, particularly the high volume of missed and mistimed calls.

Zion Domiciliary Care Hampshire provides a domiciliary care service to enable people living in Farnborough and the surrounding areas to maintain their independence at home. There were 50 people using the service at the time of the inspection, who had a range of physical and health care needs. Some people were being supported to live with dementia, whilst others were supported with specific health conditions including Multiple Sclerosis and Diabetes.

At the time of our inspection the service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal

Summary of findings

responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. During the inspection we were informed by the provider that the registered manager had resigned from their position on 5 December 2015, effective from the 7 January 2016.

People were not always protected from abuse and avoidable harm. Where abuse had been identified the provider had not taken immediate steps to prevent the abuse or taken action to ensure the abuse was not repeated.

The Provider had not ensured people were safe because they had not always provided care and support in accordance with people's individual care plans. People who required two staff to support them with moving and positioning frequently had just one member of staff attend to them, thereby placing people and staff at risk of physical harm.

We found that the provider had not ensured that people had been protected from the risks of unsafe care because people's needs had not been appropriately assessed and reviewed. Care plans did not contain enough detail to enable staff to meet the individual needs and preferences of people. Where risks had been identified staff did not always deliver care in accordance with the risk assessment management plans to keep people safe.

There were not enough staff deployed to meet peoples' needs. People we spoke with were frustrated at the high level of missed and mistimed calls. The provider was actively recruiting more staff, although current staff were disillusioned and continuing to leave.

The provider did not have a robust selection and recruitment process and had employed staff without obtaining all of the relevant information to ensure they were suitable to provide care and support to vulnerable people.

People were not supported to have their assessed needs met by staff with the necessary skills and knowledge. People were sometimes supported to mobilise without the correct equipment and advice from health professionals was not always followed.

Most people told us they were able to see other health professionals and that care staff knew about their appointments and supported them with these where required. Staff had recognised changes in people's needs and raised concerns about their health with relevant health professionals.

Staff obtained consent from people before providing their care, which had been confirmed by people we spoke with or their relatives. However, staff were unable to demonstrate an understanding of the principles of the Mental Capacity Act (MCA), 2005 or describe how they supported people to make decisions where required. People were cared for by staff who had not received relevant training and did not understand their responsibilities in relation to the MCA 2005. The provider could not be assured that staff always obtained valid consent from people.

People were not always supported to have sufficient to eat and drink at the right time. People or their relatives were concerned that the high volume of mistimed calls meant that people often did not wish to eat or drink anything, or were eating at the wrong time. For example people regularly experienced late breakfast calls at lunchtime.

Positive and caring relationships which had been developed with continuity of staff were being undermined by chaotic rostering. People told us that they were asked about their support and were involved in making decisions about their care and treatment. Some people told us they were not always spoken to in an appropriate manner and they were not always respected by the care staff.

People and their relatives told us their care visits, particularly in the morning, promoted their independence for the rest of the day. Missed or mistimed visits had an adverse impact on their independence. People said It was distressing to wait until late morning, often in soiled clothes, waiting to begin their day to day life which made them miserable.

Care plans did not reflect the different needs of each individual. There was no process for reviewing care plans to record people's changing needs. This meant the provider could not be assured that staff had the correct information and guidance about how to care for people based on their current needs.

The provider did not routinely listen and learn from people's concerns. Numerous complaints had been made

Summary of findings

to the local authority because people had become frustrated with the lack of response to their complaints by the provider. Due to these complaints a significant number of people had sought alternative care provision elsewhere.

The registered manager and provider had failed to notify the CQC that they had moved the location of their office. During the first two days of our inspection the service had no internet or telephone connection and communication was being managed on the out of hours duty phone. This meant the provider could not be assured that the service was being run properly and people were receiving care to meet their needs.

People told us the service was poorly managed and lacked leadership. People were disillusioned with the management of the service due to concerns regarding missed and mistimed calls. These concerns were then exacerbated by repeated failure to respond to complaints.

Quality assurance systems were in place but had not been operated effectively, which meant the provider had not identified the concerns discovered during our inspection. Failure to assess and monitor the quality of service meant the provider was unaware of areas that were inadequate and had not taken action to address them.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

During the inspection we identified a number of serious concerns about the care, safety and welfare of people who received support from the provider. We found nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking further action in relation to this provider and will report on this when it is completed.

Summary of findings

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 were not always protected from abuse and avoidable harm. Staff had not undertaken required training about how to protect people from abuse.

Risks to people were not always assessed to ensure people were protected from harm.

The provider did not ensure there were sufficient numbers of suitable staff at all times to keep people safe and meet their needs, which led to numerous missed or mistimed calls.

Appropriate checks were not undertaken to ensure suitable staff were employed to support people in their own homes.

The registered manager could not be assured that staff responsible for the management and administration of medicines were suitably trained and competent do so.

Is the service effective?

Inadequate

The service was not effective.

People were not supported by staff who had received adequate training, supervision and appraisal to carry out their roles effectively.

People were cared for by staff who had not received relevant training and did not understand their responsibilities in relation to the MCA 2005. The provider could not be assured that staff always obtained valid consent from people.

People were not always supported to have the food and drink they needed at the right time.

Is the service caring?

Inadequate

The service was not caring.

People were not respected by some staff, who were unfriendly and often rude. People were not treated with dignity and respect.

Missed or mistimed visits had an adverse impact on people's independence, which resulted in them being unhappy.

Positive and caring relationships which had been developed with continuity of staff were being undermined by chaotic rostering.

Is the service responsive?

Inadequate

The service was not responsive.

People had experienced missed and mistimed calls which often led to them not being able to attend social events which impacted on their well-being.

People's care plans were not personalised and lacked the information that staff required to ensure their needs were always met.

Summary of findings

The provider did not have an effective complaints procedure and people's complaints were not always responded to and acted upon.

Is the service well-led?

Inadequate

The service was not well-led.

The service culture was not open and people's concerns were not listened to or addressed by the provider.

Poor management and leadership had resulted in the poor organisation of care visits and staff supervision, which had an adverse impact on the quality of people's care.

Quality assurance systems to monitor the service provided to people were not effective. As a result the provider could not be sure of the effectiveness and safety of the care provided to people.

Zion Domiciliary Care Hampshire

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 initially took place on 19 and 20 November 2015 and 2 and 3 December 2015. The inspection was announced. The provider was given 24 hours notice of the inspection to ensure that the people we needed to speak with were available. The inspection team consisted of one inspector.

We carried out this inspection in response to concerns that had been raised to us regarding the quality of care being provided by the service. We had not requested a Provider Information Return (PIR) from the service. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Information from the PIR is used to help us decide the issues we need to focus on during the inspection.

Prior to the inspection we reviewed information held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law. We also reviewed local authority contract monitoring reports and spoke with the commissioners of the service.

During the inspection we spoke with the registered manager and the nominated individual with overall responsibility for supervising the management of the service. We also spoke with the deputy manager, the officer administrator and six staff.

On 8 and 9 December 2015 we spoke with 15 people and six relatives on the telephone to find out about their experience of the quality of care provided by the service. We reviewed 14 people's care plans and 14 staff recruitment and supervision records. We also looked at information relating to the management of the service, which included the service computer records and the provider's policies and procedures.

Inadequate

Is the service safe?

Our findings

People were not always protected from abuse and avoidable harm. This was because the provider had failed to protect people by using incidents to identify potential abuse and take preventative action to keep people safe. In October 2015 a person experienced a fall in their home. They were scheduled to receive a morning visit at 08.00 am. However the member of staff did not arrive until 12.00 pm to discover the person collapsed in the hallway. Staff contacted emergency services who gained entry and administered first aid. The person was confused and did not know when the fall had occurred. They were taken to hospital where examinations later indicated they had had a stroke. Although it was not possible to identify when this had occurred, if staff had arrived at the scheduled time this may have prevented the person falling or ensured they received emergency treatment as soon as possible. The service had failed to protect the person from suffering abuse through neglect because they did not provide care at the specified time. The registered manager did not notify this incident to the Care Quality Commission and could not demonstrate what they had done to investigate the circumstances, when asked.

A relative had raised concerns with the registered manager regarding missed and mistimed calls and had eventually notified the local safeguarding authority. The registered manager did not follow local safeguarding arrangements to make sure the allegations were investigated and had therefore failed to respond to the findings of any investigation

The service had policies and procedures for safeguarding people against abuse but did not have up to date local authority or government guidance available and accessible to members of staff. This meant staff were not enabled to have the necessary knowledge and information to make sure people were protected from abuse.

The provider's computer records system identified that no staff, other than the registered manager had completed safeguarding training. Staff files we reviewed contained no certificates to confirm staff had completed safeguarding training. New staff had received safeguarding training during their induction. New staff we spoke with were unable to demonstrate knowledge about who to contact to make referrals to or to obtain advice from at their local safeguarding authority, when responding to allegations or suspicions of abuse. Systems and processes had not been established and operated effectively to prevent the abuse of people.

The registered manager had failed to protect people from suffering abuse through neglect. They had not ensured that allegations were notified, reported and investigated. They had not ensured that staff undertook the required safeguarding training and establish and operate systems to prevent the abuse of people, which amounted to a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people were not always assessed or recorded within their care plans to ensure people were protected from harm. Some people told us that two care staff were required to support them to move safely, for example when transferring from their bed to a chair. This was confirmed by their care plan. They told us that frequently only one member of care staff arrived to provide care. This led to a family member being asked to support one member of care staff, thereby placing them at risk of harm. One relative told us, "This is happening two or three times a week." Another person told us, "I've been waiting a year for a risk assessment. I had it done in the last week but it's incorrect. It says I've got an electric wheelchair but I haven't". The provider was not assessing or meeting peoples' needs which placed them at risk of harm.

Some people had care plans which identified they required support with more complex needs. However the needs identified had not then been subject to a risk assessment. For example some people had experienced amputations and had been identified to require support with diabetes. One person's care plan informed staff that the person was 'diabetic and follows a suitable diet for her condition.' Another care plan stated, 'They have type diabetes so don't use sugar'. Neither person had a risk assessment or diabetes management plan completed to inform staff how to support them safely.

Where people had been diagnosed with dementia risk assessments had not been completed to inform staff what support was required and how they preferred to receive it. One person had written a letter to the registered manager providing comprehensive details about the care and

support they required in relation to living with their dementia. However the registered manager had not completed a support plan to inform staff how to support this person living with their dementia.

The provider had not done all that was reasonably practicable to mitigate risks to people's safety. They had failed to ensure staff followed good practice guidance to make sure the risk was as low as possible. This amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Without exception all of the people and their relatives we spoke with told us they had experienced missed calls or mistimed calls. People told us they had not received rotas so never knew which staff were coming. The member of staff attending and times of attendance seldom reflected those detailed within people's care plans. Many people supported by Zion Domiciliary Care Hampshire were older and frail, whilst some were living with dementia. People, or their relatives, told us it was important for them to know who was coming and when, so they felt safe and reassured. They told us that continuity of care from staff they knew and trusted was also vitally important to their mental wellbeing. People and their relatives, told us they had experienced poor continuity of care and had no confidence in Zion Domiciliary Care Hampshire. People did not feel safe or reassured by the quality of the service. One person said, "Last week I had no care on Monday, Tuesday, Thursday and Friday nor have I had any today yet. My wife has to take over and do it". People did not receive a service which was safe and met their needs.

People told us they had experience of calls being either far too early or late to meet their needs effectively. Without exception all of the staff we spoke with told us they were frustrated with the level of missed or mistimed care calls. Staff told us they had frequently received rotas for Monday morning at midnight on the preceding Sunday, which records confirmed. Staff told us that their rotas were always updated and changed throughout their working day. Staff told us they were always rushed because there was no travelling time between calls, which had an adverse impact on the quality of care they provided.

At the time of our inspection the service computer records identified there were 525 unallocated calls for the following week. Computer records demonstrated on previous weeks there were also numerous unallocated visits. The registered manager told us they had covered all unallocated calls shown on the computer system but could not demonstrate how they had done this without referral to individual daily notes. This was not consistent with the experience of people and their relatives. The registered manager was unable to state or demonstrate how many missed or mistimed calls people had experienced. The registered manager told us that for weeks they had been "working in the field due to a shortage of staff" and they were "exhausted". The registered manager was unable to demonstrate how they completed any staffing needs analysis to ensure they had sufficient numbers of qualified staff to meet people's needs.

The number of missed calls evidenced by the experience of people and staff, corroborated by the service's lack of resilience to cover unforeseen staffing demands demonstrated the service did not have sufficient numbers of suitable care staff to deploy to meet people's needs and ensure their safety. These concerns amount to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Appropriate checks to ensure staff were recruited safely were not carried out. Some staff did not have appropriate references in relation to their previous employment and there was not always evidence supporting how the provider had assessed applicants suitability for the post. All of the care staff files reviewed had deficiencies. Where references had been requested these had not always been received or did not address the care staff's suitability to support vulnerable people. The provider had not always completed Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Two staff files were missing completely for staff who were shown on the latest service payroll and electronic call monitoring system. The registered manager could not provide any explanation as to where these files were. The service had no documentation to confirm the identity or previous history of these staff.

Staff told us applicants attended an interview to determine their suitability. However, interview records were not always available to evidence how the provider had assessed applicants suitability to meet the requirements of the role. A new member of staff told us they had commenced working unsupervised before their DBS check

Inadequate

Is the service safe?

had been completed, which their staff file confirmed. This meant the provider had not assured people were protected from the risk of receiving their care from staff who were unsuitable to deliver support to them in their homes.

The provider had not protected people by ensuring that the information required in relation to each person employed was available. This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not protected people from the unsafe management of medicines. The service had medicines management procedures and a policy which was in line with current legislation and guidance. However, the registered manager was unable to demonstrate that staff had received training to administer people's medicines safely. Service computer records and staff professional development demonstrated no staff had completed the required training. The registered manager could not demonstrate that any staff had their competency to administer medicine assessed. This meant the registered manager could not be sure that people had been protected from the risk of harm from the unsafe management of medicines. The registered manager could not be assured that staff responsible for the management and administration of medication were suitably trained and competent do so, which was a breach of Regulation12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People and relatives provided mixed comments in relation to the competence of staff. One person told us, “I need to be helped into bed. Some handle me with care, some don't. I think the ones that don't are very young and haven't had much training”. Another person said, “Some staff do not know what they are doing. They ask me what to do and I have to show them. That can’t be right.” Another person told us, “They know what they're doing, for example when they get me from the bed into the wheelchair they have to put the cushion in a certain position to stop my clothes from getting snagged on it. We worked it out together.”

One person had made a complaint that a member of staff had attended who did not know their needs or how to support them. The person required support to transfer from their wheelchair to a commode using moving and positioning equipment. However the member of staff had not been trained in the use of this equipment and tried to move the person without using it. This placed the person and staff at risk of physical harm.

People were not supported to have their assessed needs met by staff with the necessary skills and knowledge. The deputy manager told us they were also the provider’s training officer and had been in post since June 2015. They told us the provider had instructed them to prioritise the induction training for new staff. The deputy manager told us they had not provided any updated training for staff but were devising a programme to deliver required training starting in December 2015. At the time of inspection there was no required training scheduled. We reviewed the service computer system which demonstrated that no staff, other than the registered manager had completed required training in relation to safeguarding, moving and positioning, the Mental Capacity Act 2005, medicines management, consent to care, basic first aid or food hygiene and preparation.

New staff had received a two day induction programme followed by one day shadowing experienced staff. Two staff told us they had received an induction and training which had prepared them to fulfil their role effectively. However another member of staff said, “Training what training?” The service had a process where ‘Home Care Induction forms’ were to be completed by staff assigned to support people. These forms evidenced the care to be undertaken, whether staff understood the person’s care plans and whether staff were competent to fulfil their role. However we found that only one of the care plans we reviewed had such a form completed. The provider could not be assured that staff knew the person and had demonstrated the required competencies to deliver support to meet their needs.

Staff professional development files we reviewed did not contain certificates to demonstrate the training of individual staff. The deputy manager told us that due to staffing shortages and the requirement to cover allocated visits they had been unable arrange training. The registered manager and the deputy manager could not demonstrate that training had been completed by staff. This meant the provider could not be assured that people had their assessed needs met by staff with the necessary skills and knowledge.

People told us that staff frequently arrived who did not know their needs or how to support them. A new member of staff told us they had not received moving and positioning training, which records confirmed. However they had provided care to a person who required support to move using a slide sheet. The staff member told us they had observed staff use a slide sheet whilst shadowing but had received no formal training or assessment of their competency to use one safely. Staff had not been supervised until they could demonstrate required levels of competence to carry out their role unsupervised.

One member of staff told us how they had been providing care to a person who required a convene. A convene is an aid to support people with incontinence. The member of staff told us they had received no training or competency assessment in how to use this device. We read a complaint from this person relating to staff who did not know how to manage their convene. This placed the person at risk of personal harm. People had received support from staff who had not undertaken the required training to meet their needs.

Staff told us they had should have a quarterly one to one supervision meeting with their line manager. They should also have a spot check where their care practice was observed and assessed by a supervisor, and an annual appraisal. Staff told us they had not received a supervision, spot check or appraisal. The registered manager was unable to demonstrate they had completed any supervisions, spot checks or appraisals. Staff professional development files we reviewed did not contain any

Inadequate

Is the service effective?

supervisions, spot checks or appraisals. We reviewed the service supervision file and noted the last supervision recorded was in July 2014. Staff had not received regular appraisal or assessment of their competence from appropriately skilled and experienced supervisors.

The provider had not ensured care staff had received appropriate training, professional development, supervision and appraisal to enable them to carry out their role effectively. This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said the care staff always asked for their consent before they did anything and involved them in decisions. One person told us, "They always ask me if it's okay before they start to do anything". Another person said," They say things like, 'are you okay for me to do this?', before they help me." However care records did not demonstrate that people had signed and given consent for various aspects of care.

The service did not carry out mental capacity assessments. The deputy manager explained this was because the Local Authority had undertaken the necessary assessments before people joined the service. Some people had been with the service for over a year which meant people's changing needs with regards to their mental well- being had not been reviewed.

Staff told us the Mental Capacity Act (MCA) 2005 had been discussed briefly during their induction process but they had not completed any detailed training. Staff training records and the deputy manager confirmed this. The MCA 2005 provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. Staff were unable to demonstrate an understanding of the principles of the act or describe how they supported people to make decisions. People were cared for by staff who had not received relevant training and did not understand their responsibilities in relation to the MCA 2005. The service had medicines management procedures and a policy which was in line with current legislation and guidance. The medicines policy stated there must be documented consent for staff to support people with their medicines. There was no evidence of consent documented in the care plans reviewed. The provider could not be assured that staff always obtained valid consent from people. This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported to have sufficient to eat and drink at the right time. People or their relatives were concerned that the high volume of mistimed calls meant that people often did not wish to eat or drink anything at the time of the call, or were eating at the wrong time. For example people regularly experienced late breakfast calls followed shortly by early lunchtime calls. Relatives told us they were worried their family members were therefore missing an important meal daily.

Most people told us they were able to see other health professionals and that staff knew about their appointments and supported them with these where required. Staff had recognised changes in people's needs and raised concerns about their health with the office staff who then referred them to other professionals.

Inadequate

Is the service caring?

Our findings

People told us that they thought some of the staff were kind and caring. They said, however, there were some staff who were not kind and caring and they did not like them providing their care. One person told us, “There is one regular girl but she doesn't work full time. She's excellent. The others are a bit different. I can't explain what it is and I can't tell the manager. They just haven't got a caring way”. Another person told us, “Some carers are in and out in five minutes. This happens when the regular carers are off. It’s just not very caring. They are not necessarily inexperienced, it just seems like a box ticking exercise and they're in and out quickly”. Another person told us “The one I've got at the moment is nice but she can't work seven days. The one who takes her place isn't in the right job. All she did yesterday was put my socks on. She is meant to help me get dressed but she said she had to be on other calls and was already late”. Another person talking about staff said, “One of them said it took 10 minutes for me to take my pills and it was wasting her time”, which they found distressing.

Due to the poor continuity of staff they were not familiar with the people they were caring for. Staff routines and preferences took priority which resulted in them having little understanding of the impact of this approach on the wellbeing and needs of people.

Some people and relatives had raised concerns about the manner in which some staff spoke with them, including the registered manager. One person told us staff were late for their morning call and they were expecting the imminent arrival of guests. The registered manager arrived to provide the personal care required but the person declined because of their guests’ imminent arrival. The person then told us the registered manager did not listen when they repeatedly told them they did not wish to receive personal care. At this point the registered manager then became silent and refused to talk to the person. This matter has been subject to a formal complaint by the person’s family.

People and their relatives told us their care visits, particularly in the morning, promoted their independence for the rest of the day. Missed or mistimed visits had an adverse impact on their independence. People said It was distressing to wait until late morning, often in soiled clothes, waiting to begin their day to day life which made them miserable.

People were not assured that information about them was treated confidentially and respected by staff. People and relatives told us that some of the staff were not able to drive. The service had employed a driver during October and November 2015 without first completing relevant pre-employment checks. This driver had since resigned. People told us that on occasions the relatives of staff had driven staff to people’s addresses to provide care.

People were not given information and explanations they required at the time they need them. This was particularly evident in relation to missed and mistimed calls. People told us they were never informed when staff were going to be late or not available. One person told us, “No one rings if they're going to be late, I leave messages but no one ever gets back to me. Getting to other activities is distressing if they haven't turned up”. Another person told us that office staff had been rude and offensive to them when they rang to report they had not received their morning care visit. This was confirmed by the deputy manager who told us they had implemented the service discipline procedure in relation to the staff member who had then resigned.

The lack of respect shown to people by staff and the failure to promote people’s independence was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The systems to monitor people’s views about their care and to ensure people felt that staff were caring towards them were not effective. There were numerous concerns and complaints raised by people and their relatives about the quality and consistency of care and appropriate action had not been taken by the provider to improve the service.

Inadequate

Is the service responsive?

Our findings

Care provided by staff was not always personalised to meet people's needs. People told us that missed and inconsistent calls often led to them being unable to attend social events at day centres and other activities they enjoyed. They told us this had a big impact on their well-being and had the potential for them to become socially isolated.

We spoke with staff about their understanding of people's care plans, risks to their care and how they used them to provide the correct care for people. One care staff told us, "They don't provide enough detail about the person so you can get to know them and understand them." Another staff member told us, "Because we are always having our calls changed at the last minute you are often sent to people you don't know. One day I was sent to a gentleman who was collapsed in his toilet. I didn't even know he was deaf". One person who had recently experienced three different surgical procedures affecting their mobility and general health told us, "I just wished the carers knew about all of my needs but some don't know anything about me."

People's care plans did not all contain the person centred information that care staff required in order to get to know people and provide personalised support. People's care plans did not contain relevant information about their life history, their home and family, and things which were important to them. Care plans were generic and focused on tasks, and did not reflect the different needs of each individual. People did not receive individualised person centred care.

Care plans did not provide important information regarding people's health conditions and how to respond to these. For example people were living with multiple sclerosis and dementia. There was no guidance for staff to support people appropriately whilst delivering their care to people with these conditions. This meant there was a risk that people would not receive the care they needed.

Care plans were not up to date and had not been recently reviewed. Some people did not have a care plan whilst others had not been reviewed since 2014. People told us that staff were not always consistent in the care they provided. One person told us, "Some carers just stand there waiting for me to tell them what to do. They haven't got a clue. " People's needs were not met by staff because their care plans had not been updated in response to their changing needs. The provider was not responsive to people's changing needs and did not update care plans appropriately.

The process for reviewing care plans was not robust. Care plans had not been updated and reviewed because there was no system in place to ensure all care plans were updated regularly. At the time of our inspection. The provider could not be assured that care staff had the correct information and guidance about how to care for people based on their current needs. There was a risk that people would not receive appropriate care which responded to their assessed needs.

The provider had failed to make sure that people received care and treatment that was appropriate, met their needs and reflected their preferences. This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was not responsive to people's complaints. Complaints were not always dealt with in an open, transparent and objective way. Most people told us that they knew they could make a complaint, but not everyone was clear about the process. The provider had a complaints policy and procedure, although this was not always followed in practice. The registered manager was unable to tell us how many complaints the service had received. The registered manager was unable to demonstrate how they had analysed complaints to identify trends to drive improvements in the service. We reviewed the provider's complaints file and found there had been 19 complaints recorded in 2015. Six of these people had sought alternative care provision. These complaints did not demonstrate that people's concerns had been thoroughly investigated and resolved to their satisfaction. The deputy manager and office coordinator told us that the provider's computer records demonstrated there were many more complaints which had not been subject to the provider's complaints procedure. We reviewed the provider's computer records and found a number of incidents which had not been formally recorded as complaints. The deputy manager told us that numerous complaints had been made to the previous office administrator which had not been entered onto the computer events logs so there was no record or guarantee that the complaints were looked into. This meant that people's concerns and complaints had not been explored and responded to appropriately.

Inadequate

Is the service responsive?

The provider's failure to record, investigate and take proportionate action in relation to complaints was a breach of Regulation 16 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When people moved between services appropriate risk assessments must be undertaken to make sure their safety is not compromised. One person told us how they had been discharged from hospital and did not receive their night time call. This meant they were left sitting in an armchair overnight. No risk assessment had been completed to ensure the person's safety and welfare was not compromised on their discharge from hospital. This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The registered manager did not understand their responsibilities and was not supported by the provider to deliver what was required. The Registered Manager of Zion Domiciliary Care Hampshire was registered to carry out the regulated activity of personal care from 46, Camp Road, North Camp, Farnborough, Hampshire GU14 6EP. On the first day of our inspection the Registered Manager was carrying out the regulated activity of personal care from The Old Bank Chambers, 3-5, Alexandra Road, North Camp, Farnborough, GU14 6BU. The provider and registered manager had failed to submit an application without reasonable cause to add this location to their registration and remove the previous location. This meant the provider and registered manager had failed to comply with the conditions of their registration contrary to Section 33 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and provider had failed to notify the CQC that they had moved the location of their office. During the first two days of our inspection the service had no internet or telephone connection and communication with people was being managed on the out of hours duty phone. These facilities had remained unconnected for at least five days. The registered manager had failed to notify the CQC of events that stopped the service operating safely or properly. This was breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The service demonstrated poor management and leadership. The service had appointed a deputy manager in June 2015 but they had not been provided with a job description and were unsure what was expected of them. They told us they were also the provider's training manager. The registered manager spent most of their time providing care to people and was rarely in the office managing the service. When speaking with the registered manager and deputy manager both held opposing views about their individual roles and responsibilities. For example who was responsible for updating the service computer records and audits of care records, daily notes and medicine administration records. An office administrator had been appointed the week before our inspection who had not been provided with a job description or their roles and responsibilities. The service did not have any other staff responsible for the coordination and allocation of care visits or supervision of staff care practice. Throughout the inspection the registered manager was frequently unavailable to discuss their management processes because they were delivering care.

The provider had systems in place to monitor and audit the quality of service provision but failed to operate them effectively. This meant the provider could not be sure of the effectiveness and safety of the care provided to people.

The provider's computer system had the capability to generate audit reports about care plans, risk assessments, medicines management, staff training, supervisions and call allocations, to allow the registered manager to assess and monitor all aspects of service delivery and drive necessary improvement. However the registered manager did not operate this system. The registered manager could not demonstrate any other form of audit process outside of the provider's computer records to monitor the completion of care records, risk assessments, staff supervisions and training. The provider could not be assured of the quality of service provided to people.

The provider's computer system demonstrated that 56 out of 60 people required either a care plan or risk assessment to be completed. The registered manager could provide no assurance or demonstrate how many people had a care plan or risk assessment completed. This meant that people were at risk of receiving care and support from staff who had not been provided with the required information to meet their needs. The provider's computer records demonstrated that the registered manager was the only member of staff who had completed the provider's required training. The registered manager could not demonstrate the training undertaken by other staff. This meant people were at risk of receiving support from staff who had not completed required training to meet their assessed needs.

The provider did not have any system or process requiring the registered manager to report to them significant events such as the number of late, early and missed visits; complaints received and; recruitment, retention and supervision of staff. The lack of audits meant the provider did not have a detailed understanding of the care being provided to people and how to effectively manage the service. If these had taken place, the provider would have identified the breaches of regulation 9, 12, 18, and 19 that we identified at this inspection.

Inadequate

Is the service well-led?

The provider had failed to effectively operate systems and processes to assess, monitor and improve the quality and safety of the services provided. This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and staff told us the service was poorly managed and lacked leadership. People were disillusioned with the management of the service due to concerns regarding missed and mistimed calls. These concerns were then exacerbated by the repeated failure of the provider to respond to complaints. One person told us, “I had to have a go at them. They come at 8 o'clock and will be gone by five past. I've told the manager. I complain but nothing's been done”. Another person told us I've raised the problem to adult services but if I complain too much she (the registered manager) drops your care”. Another person told us “Four to five months ago I had a questionnaire but nothing's been done. There is a lack of communication”.

Staff told us that the organisation and coordination of care visits was chaotic. One care staff told us, “You don’t get rotas until the day before and you know they will change during the day. Staff we spoke with were uncertain who their line manager was or the individual responsibilities of the office staff.

People and staff personal records were not kept secure at all times. On the first day of our inspection we observed various personal documents piled on large tables and the floor of the main office. Prior to leaving the office we advised the registered manager that all of the confidential documents would need to be placed in a secure lockable cabinet. After the registered manager had left for the evening we observed there were numerous confidential documents still on the tables and floor of the office in plain sight. The deputy manager who was in the process of leaving for the evening was informed and then returned to place the documents in a secure location. The failure of the registered manager to keep records secure at all times and accessible only to people and staff who are authorised to do so was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.