PerCurra Limited

Percurra

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This announced inspection was carried out on 26 January and 4 February 2016. Percurra provides a service to adults living in their own homes. The service provides care and support to adults with a learning disability, mental health conditions, physical disabilities and sensory impairments. At the time of the inspection there were approximately 30 people using the service who received personal care.

The service had a registered manager in place at the time of our inspection. 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.

Where people had experienced, or were at risk of experiencing abuse or harm, the procedures in place to protect them were not followed. People did not always receive the care and support they wanted because there were insufficient staff to provide this.

People may not always receive their care or any medicines they take as safely as they could do because the safest practices for them to do so were not always recognised or followed.

There were times where people were supported by staff who did not have the right skills and knowledge to meet their needs.

People were asked for their agreement to their care and had opportunities to provide written consent. People were supported to maintain their health and have sufficient to eat and drink.

People did not always have a caring experience due to systems not always being effective in allocating the right staff. People were able to request flexibility with their care and support.

People who had raised concerns and complaints about their care did feel these had been considered and rectified. People's plans of care were not kept up to date and did not contain all the information staff needed to meet their needs.

People had mixed views on how well the service was run. Where people came across problems they did not have a positive experience but other people who did not encounter problems spoke positively about the service. There was not the information available to ensure quality monitoring systems identified where there were problems within the service, and how these could be corrected.

The provider has not notified us of events there were required to.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

People were at risk of harm or abuse because systems in place to prevent this were not followed.

People did not always get the service planned for them because there were insufficient staff with the right skills to provide this.

People did not always receive their care in the safest way possible and their medicines were not always given as intended.

Is the service effective?

Requires Improvement

The service was not always effective.

There were occasions when people were supported by staff who were not suitably trained and supported to meet their needs.

Opportunities for people to give consent and make decisions for themselves were being improved.

People were supported to maintain their health and have sufficient to eat and drink.

Is the service caring?

Requires Improvement

The service was not always caring.

People had mixed experiences regarding how kind and caring their support was.

People were able to request flexibility with their care and support.

People were shown respect and courtesy by staff visiting them in their homes in a way that suited them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's plans of care and support did not always have the required information in. They were not always kept up to date and reviewed regularly.

People who had concerns and complaints about their care did not feel they were listened to or that these were acted upon.

Is the service well-led?

Inadequate

The service was not well led.

When people had problems and difficulties with their service these were not always recognised and addressed.

Systems to monitor the quality of the service people received were not effective.

We were not informed of events in the service that the provider is legally required to inform us about.

Percurra

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 on 26 January and 4 February 2016 and was announced. The provider was given 24 hours' notice because the location was a domiciliary care agency and we wanted to ensure there was someone free to assist us with the inspection. The inspection was carried out by four inspectors.

Prior to our inspection we reviewed information we held about the service. This included a Provider Information Return (PIR) completed by the provider. 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. We looked at previous inspection reports, information received and statutory notifications. A notification is information about important events and the provider is required to send us this by law.

During the inspection we spoke with 12 people who used the service and three relatives. We also spoke with seven care workers and various members of office staff including a care coordinator, a field supervisor, the scheduler, the registered manager and the managing director.

We looked at a range of records kept as part of the running of the service. This included the care records for nine people, the staff training matrix and other records kept by the registered manager as part of their management and auditing of the service.

Requires Improvement

Is the service safe?

Our findings

Although there were systems in place to inform staff about safeguarding and how to raise and report any concerns and staff had knowledge in respect of this we found people may not be protected from harm or abuse because the procedures that were in place to safeguard people were not being followed. The provider is required to notify the local authority without delay in the event of any abuse or allegation of abuse concerning a person who uses the service.

We found one person had made an allegation of physical mistreatment by a member of staff which should have been reported to the local authority multi-agency safeguarding hub (MASH) who receive any safeguarding concerns for people who live in Nottinghamshire. This had been recorded as a complaint in the provider's complaints log and no action was taken.

We also saw a letter written by a person who used the service which alleged they had not been provided with their personal care during a personal care call one morning. This should have been reported as a concern about the person's safety to MASH.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not sufficient numbers of suitable staff employed to keep people who used the service safe and to meet their needs. We were told prior to and during our inspection by people who used the service about staffing levels having an impact on the care and support they should be receiving. This included only one member of staff attending a call which required two staff to ensure the care was delivered safely. A person told us they were meant to have two staff attend most of their calls, but frequently there was only one who attended so the person may not receive safe care.

During the inspection a number of people we spoke with referred to some of their calls being late. A person who used the service told us, "The carers are great but there are instances of not having staff to cover. They ring up and say we can't get someone to you. It used to be occasional but it's getting quite regular now."

Some staff told us they did not always have the correct number of workers planned for each call. One staff member told us some calls that required two staff to visit have had on occasions been reduced to one staff member due to a lack of available staff. They said, "We wouldn't do it on our own, we have had to ask a relative to help." However we were told by some staff that they had been asked to carry tasks that required two staff on their own when a relative was unavailable to help. A staff member told us they knew of some staff that had done so on a number of occasions.

Prior to the inspection we had been contacted by current and ex staff who raised concerns at the lack of staff and calls being made late. They also told us there were occasions when only one staff member attended a call when two staff were required.

Staff told us they did not think there were sufficient staff employed to cover all the calls. Some staff said they got regular text, email or phone messages every day wanting to know if they could cover unallocated visits. The managing director told us this was part of the five stage process they followed to cover calls that are unallocated due to sickness or other staff absence. However we found this was not always effective as some office based staff told us they had been prevented from completing their jobs as they had to spend a lot of time covering calls they did not have care workers to allocate to. A staff member told us they got a lot of complaints from people who used the service about the lateness of their calls. Another staff member said, "An issue is a lot of clients calls are left uncovered. The communication from the office is terrible."

The managing director told us there had been a shortage of staff due to some staff leaving and it was taking time to recruit new staff. They also told us that they had an extra team of staff available to attend to calls in the event of sickness and they had been using this team as back up staff. They also informed us that there had been no missed calls where two members of staff were required. They said these would only be changed to one member of staff if the person using the service requested this and this information would be provided in people's care plans. However we did see records made in a person's home that showed there had been some late calls. The records also showed some calls that required two staff had been attended by one staff member.

As part of our monitoring of services we ask people who use the service and staff to complete a questionnaire stating whether they agree or disagree with a set of statements. Five people who used the service responded to the statement "My care and support workers arrive on time" which 60% agreed and 40 % said they disagreed with. The response to, "I receive care and support from familiar, consistent care and support workers" was that 40% agreed and 60% disagreed with. Four staff responded to the statement "My work and travel schedule means that I am able to arrive on time and stay for the agreed length of time" which 50% agreed and 50% disagreed with.

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

People who required equipment to assist with their care had this in place, however this was not always being used safely. A relative told us that on one occasion during a personal care call staff from the office had talked staff through the hoisting procedure over the phone as they had not known what to do. They said this had a negative impact on their relation who now "expected the worse" when they had a personal care call.

A staff member told us that one person required regular repositioning to protect their skin from pressure damage and developing a pressure ulcer. Records kept to show when the person was repositioned had been completed by one member of staff on a number of occasions. The registered manager said that when the person was repositioned in bed this could be done safely by one member of staff. On other occasions the person required two staff to reposition them using a hoist to ensure they were transferred safely. Records showed only that on some occasions only one staff member had signed the repositioning form when a hoist was needed. We were unable to establish if the person had been moved incorrectly or if the records had not been completed correctly.

People may receive unsafe care because there was a lack of detail and descriptions of actions staff should take in risk assessments. For example one person was at risk of choking but the risk assessment for this did not refer to staff being trained in first aid. The training matrix showed some staff who supported the person had not been trained in first aid. Additionally there was insufficient detail provided in the guidance on how staff should administer a medicine prescribed to be used in an emergency.

People were being supported with their medicines by staff who did not all have the skills to support people safely. The provider told us in the PIR that staff had their competency assessed to ensure they were safe to support people with their medicines. We asked the managing director to show us the medicine competency forms but despite our request we were not shown these for a number of staff who administered medicines. A staff member who we were told carried out the competency assessments said, "I have got medicine competency forms, but I haven't done one for a while being honest."

One person told us of an occasion a staff member had dropped a medicine onto the floor and the staff member had picked it up from the floor with bare hands. They had then administered it, ignoring good hygiene practice.

Following the inspection the registered manager sent us an email which included a report that stated the staff member concerned was safe to continue administering medication at the person's home. This was because Percurra's medication lead undertook a personal training one-to- one session with the member of staff the morning after they were alerted of a probable medication error. This was the same morning as the medication lead had recorded the concerns about the member of staff's practice in the medicine competency assessment. This did not show that that the member of staff concerned had made the improvements needed to ensure they administered medicines safely or that if they had these would be sustained.

We looked at the medicine administration records (MAR) in the office file and found that there were some months missing and those we saw were not fully completed. We saw some MAR sheet entries had not been completed to show creams and eye drops were administered when needed.

Although we had concerns and found breaches of our regulations, some people who used the service told us they felt safe doing so. One person said, "I feel I have always been safe with them." Another person said, "I've got lovely team of carers and I feel safe with them." A different person said, "I have got confidence I will be safe with them that is a big thing for me."

As part of our monitoring services we ask people who use the service and staff to complete a questionnaire stating whether they agree or disagree with a set of statements. Five people who used the service responded to the statement "I feel safe from abuse and or harm from my care and support workers" which 100% agreed with. Four staff responded to the statement "I know what to do if I suspect one of the people I support was being abused or was at risk of harm" which 100% agreed with.

People received care and support in an environment that had been assessed for any hazards which could affect people's safety. A person who used the service told us, "They do provide your care safely." Another person said, "I feel I have always been safe with them when they care for me."

We asked a care coordinator how they ensured people could receive any care safely in their own home and they said, "We carry out an assessment of the environment." They also told us that any equipment they needed was provided, and any requests for new equipment were responded to promptly. They also said that the equipment was in good order and there were risk assessments in place. The provider said there was sometimes a delay when waiting for people to be assessed by the local authority teams to determine what equipment they needed, but they would work around this until the equipment was in place. We saw copies of environmental risk assessments were on people's files.

People were supported by care workers who had been through the required recruitment checks to preclude

anyone who had previously been found to be unfit to provide care and support. These included acquiring references to show the applicants suitability for this type of work, and whether they had been deemed unsuitable by the Disclosure and Barring Service (DBS). The DBS provides information about an individual's suitability to work with people to assist employers in making safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

We received mixed comments and information from people who used the service and staff about whether staff were sufficiently trained to support people safely. People who used the service we spoke with and their relatives commented that they did have staff provide personal care who were suitably trained. However they also provided examples when staff had attended a call who they felt did not have the skills required to meet some of the person's needs.

One person who had contacted us prior to the inspection said, "A lot of the carers don't know what they are doing. If they do send two carers, one stands looking because they don't know what to do." A person who used the service told us that it was not always ideal to have an inexperienced worker come to carry out their care and support due to their complex needs. A staff member said the person got upset when staff who came to care and support them were not confident in how to meet their needs. A relative told us they did not believe the staff got the right training. They told us a staff member was not wearing protective gloves during personal care and had stated, "I'm sorry I don't know what I'm doing."

There were experienced staff allocated to provide other staff with supervision, some staff told us they were not getting the supervision they needed to support them in their role. The registered manager said that field based supervision, which is where staff are supervised in the work place had, "Not fallen behind" but reflective supervisions, which occur out of the work place to discuss work on a one to one basis "May have dwindled a bit."

As part of our monitoring services we ask people who use the service and staff to complete a questionnaire stating whether they agree or disagree with a set of statements. Four people who used the service responded to the statement "My care and support workers have the skills and knowledge to give me the care and support I need" which 50% agreed and 50% disagreed with. Four staff responded to the statement 'I get the training I need to enable me to meet people's needs, choices and preferences' which 100% agreed with. Nevertheless despite these responses, we found some people who had more complex needs were sometimes supported by staff who had not been trained in how to meet these needs. During our inspection we were told by staff that they had not received the training they needed to provide care to people with more involved medicines administration needs or how to use certain pieces of equipment. The training matrix showed some staff who supported the person had not been trained in this method of medicine administration.

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 told us they were included in making decisions about their care and support. They said they were always asked by staff for their agreement prior to any care activity. One person who used the service told us

staff, "Always check I am happy with what they are doing."

We saw one person who had capacity to make decisions for themselves had signed one out of the last six care plan review forms and a record had been made that they had declined to sign another. The remaining four had not been signed by the person. We saw two people who used the service's contracts with the agency had been signed by other people. In both cases staff told us the person would have been capable of signing the contract themselves and we saw other documents one of the people had signed. Some staff told us the system for obtaining people's consent was not working properly. This meant people who used the service may have decisions made or consent given on their behalf that they were not in agreement with.

We discussed issues of consent with the registered manager who said they were in the process of implementing a new consent form and they provided us with a copy of this. This included people consenting to the care programme, the care plans and any risk assessments. This showed the provider was aware of the need to develop their system and had acted upon this knowledge and showed they understood the need for consent to different levels of treatment.

People who lacked the capacity to make certain decisions could not rely on their right to give consent and make decisions for themselves being promoted and respected. We asked a number of staff if there was anyone who used the service who was not able to make their own decisions about their care and support and received different answers. We asked the registered manager about their understanding of when they would assess a person's capacity to see if they could make a decision themselves and they told us they would not do this. They said they would refer this to a relevant health care professional or social worker, although they told us this situation had not arisen. We asked staff about their understanding of the MCA and they were not clear about this.

People who required support to ensure they had enough to eat and drink to maintain their health and wellbeing were provided with this. One person who used the service told us staff who visited them, "Always make sure I have a good evening meal. That's important." Another person said, "I get ready meals in, they heat them for me." A person told us how grateful they were that one member of staff was going to do their food shopping for the next few weeks as their regular help for this was away.

A member of staff told us they would provide the support anyone needed to encourage them to eat and drink well. They told us this included shopping and cooking when needed. Another staff member said they would ask the person what they wanted from what was available in their food cupboard and fridge. We saw the minutes of a care team meeting for one person which stated it was important that staff who supported the person were able to cook.

Staff told us basic food hygiene and promoting people's nutritional intake was included in the new starter induction programme. They also told us they provided people with any assistance they needed to help them to eat well. Where there were concerns about people's nutritional intake staff recorded their food and fluid intake so they could monitor the amount people ate.

People received support they needed with regard to their health and wellbeing. A person who used the service told us, "Last night I wasn't well and they helped me to bed." Another person told us, I have to have someone trained to see to my tracheostomy, but they train them up for that."

Staff told us they understood people's health needs and had knowledge of their heath conditions. A staff member told us, "If I have any concerns with someone's health I will call a doctor and tell the office." Another staff member told us details of people's medical conditions and healthcare support were written in

their care plans. Another said they reported any changes in people's healthcare to the care coordinator to update their care plan.

The provider had recorded on the PIR that, 'PerCurra allows clients to keep their care team during hospital admission allowing them to have safe discharge on return to their home. This is especially critical for any clients with mental health issues, dementia or learning disabilities. Potential unsafe hospital releases, due to mental health reasons, are questioned and escalated if necessary.' The registered manager told us one person who had been in hospital recently had continued to be visited by members of their care team.

Requires Improvement

Is the service caring?

Our findings

Some people had a positive experience using the service and spoke highly of the care workers who visited them. For example as part of our monitoring services we ask people who use the service and staff to complete a questionnaire stating whether they agree or disagree with a set of statements. Five people who used the service responded to the statement "I am happy with the care and support I receive from this service" which 100% agreed with. However other people had a mixed experience. At times this was because of organisational reasons such as not having the right number or correctly skilled staff attend their call. At other times it was because individual staff did not conduct themselves as expected. This included one occasion where one staff member carried out a personal care call taking their young child with them.

Some people's experience of the service was not always as it was intended to be. The aim of the service was to match staff to people according to their preferences, and to involve people in selecting their care team. Whilst this may have worked for some people, who were very happy with the service they received, there were some other people who it had not. Consequently we received comments from people which expressed these different views. On the one hand some people made comments such as, "They are like my best friends, I look forward to them coming", "Most don't feel like they are doing it for a job" and "They are sad for me and my circumstances and show it, you need a bit of sympathy at my age." However other comments included, "We have had a few issues, it's not always ideal", "It's been dreadful" and "The service has not been great."

The managing director told us how they matched staff to different people according to their preferences. They said that people could be involved in choosing the workers that were going to care for them. We found some people did have a regular team of staff who visited them and they were happy with this. However we also found some people did not have regular staff visiting them and complained at the number of changes of staff they had.

A staff member told us that they made relationships with people and a lot of staff enjoyed their work. Another staff member said, "We have got some very good staff. Our clients are forthcoming with their opinions and we get some really good feedback. They said they respected people's homes and gave an example that they would take their shoes off when entering someone's home.

There was a section in the care plan which recorded any preferred characteristics people had about the team of workers that supported them. This included any gender and age range preferences people may have and whether they would like a 'chatty' or quiet worker. The managing director told us they achieved a good mix of staff through equality monitoring.

Some people told us they were able to make changes to their care. One person said, "They are always very obliging, I will get an extra call if I need to go out." Another person said, "They will do little jobs around the house which is very helpful, I just ask them and they look after me. I have found them very good in that respect." A staff member told us people were involved in planning their care and took part in this when it was reviewed.

People were treated in the way they found respectful. A person who used the service said, "They do respect my home and leave my bedroom tidy, can't fault my carers." Another person said, "Very rarely everywhere is not left tidy, it's not a problem."

Some staff spoke with great passion about protecting and respecting people's privacy and dignity and said they would report anything they saw that compromised this. One staff member said they had raised concerns when they felt people's privacy and dignity was not being respected. Another staff member told us, "It is their house, we respect their beliefs and values."

In the surveys we sent to people who use the service and staff, five people who used the service responded to the statement "My care and support workers always treat me with respect and dignity" which 100% agreed with. Four staff responded to the statement "People who use this care agency are always treated with respect and dignity by staff" which 100% agreed with.

Requires Improvement

Is the service responsive?

Our findings

We found people's care plans were completed to variable standards. Although some care plans gave a clear description of how people's needs should be met, some had significant detail missing. We saw some plans that did not contain significant detail about the support and care people needed. For example two people who were supported with taking their medicines did not have any reference to this in their care plans. This put people at risk of not receiving their prescribed medicines as intended.

We also saw that some care plans did not contain sufficient detail about people's needs and how these should be met. For example one person's plan for personal hygiene stated 'full assistance required' but did not give any detail about the person's care needs or how they wished to be supported. A description of the support a person needed with skin care was written as "creams required at times especially to legs" but did not say what cream the person needed or exactly where this should be applied. This meant people may not receive the care they require.

Some people's care plans had not been reviewed or updated for some time and contained information that was out of date. A relative told us they had been told several months ago that their relation's care plan needed to be reviewed but this had not happened. We saw the person's care plan had last been reviewed in 2014. A staff member who was responsible for reviewing people's care told us they were behind schedule with these due to other work pressures. This meant some people's care plans had not been kept up to date with changing needs and staff may not know how to support them.

We also saw that two people who used the service from the same property had shared daily notes. This meant that each person's care could not be properly monitored as for example we saw one entry that stated 'Assisted with meds and eye drops' but staff had not recorded which person they were referring to.

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

When people's complaints were addressed using the complaint system there were improvements made to the service. However we found people used a service where complaints were not always acted on or taken seriously. Prior to the inspection a number of people who used the service had contacted us and told us they had made verbal complaints about problems they had experienced with the service. People also told us they had problems getting to speak with managers and their requests to be called back were not responded to. A person who contacted us with concerns about the agency told us that, "Clients are also not happy and their complaints are ignored at times." Other people who had contacted us also spoke of complaints not being responded to or not having telephone calls returned to them.

We saw evidence in one person's file that a relative had raised issues about their care workers since 2013 and these issues were still ongoing. None of these complaints had been recorded and so we could not be assured they had been acted on and resolved with the people making the complaints.

We discussed the complaints raised with the managing director and the registered manager and they told us they were aware of some of the issues people had raised with us, but had not seen them as complaints so had not treated them as such. The registered manager told us they recorded any formal complaint made in the complaints system which they monitored through a complaints log. She told us that 'less formal complaints' were recorded in people's care records and acted on. A lack of recording concerns raised in this way meant there was no oversight about the number or type of complaints that were received. Additionally we found that a significant complaint had been raised by a person who used the service and this had been left in their care records and not recorded on the complaints log where the provider would be able to learn from complaints to prevent further occurrences. This meant people could not be assured concerns they raised would be taken seriously.

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

The provider did not put the needs and preferences of people at the heart of the service. There was a lack of appropriate governance and risk management framework and this resulted in us finding multiple breaches in regulation and negative outcomes for people who used the service. There were systems in place to develop and improve the service, based on the needs and views of the people who used it, their families and staff. However we found these were not always followed.

There was a lack of effective systems in place to monitor missed or late visits made to people, occasions when inexperienced and untrained staff had carried out care tasks and how complaints were acted on. This had led to people being placed at risk of harm and receiving care and support that was not safe.

Some people who used the service did not feel there was a positive and inclusive culture at the service. One person told us when we asked if they felt the service was well run, "On the whole no, not by the company, better communication is needed. It would be nice to be called if changing (call) times or workers. It feels like they do what they want and we have to go along with it." Another person told us they had, "Problems communicating with managers, if you speak to customer support staff the managers do not always get back to you." A different person said, "No (it is not well led) my care coordinator [name] is good at sorting thing out if I have a problem, but not office wise."

People who contacted us prior to the inspection had raised concerns and problems about the management of the service. We found there were inconsistences in information we were given with different versions of events being told to us by people who used the service, staff and managers. On occasions people referred to events that had taken place concerning other people who used the service and there was no reason why the informant should have had this information. This implied that there were breaches in confidentiality taking place. The registered manager told us they had identified there were issues in the service.

People were not always kept informed about changes to their planned personal care calls. One person told us, "They didn't let me know who is coming, it happens a bit." One office based staff member said, "It is fair to say there are times where a client doesn't know who is coming. Staff do phone customer services and there have been occasions when this had not been told to the client."

People were provided with a service which did not have systems operated effectively to monitor the quality of the service. The managing director told us they did not have records of late calls as they had a system in place to make sure all calls were covered and as long as they were covered, these would not be recorded as late calls. Therefore the system for managing staff deployment was ineffective because it was not set up to provide information about late calls or occasions when people were not attended to by enough staff. We saw some personal records that held this type of information but it was not recorded in a way that enabled the provider to monitor staff deployment.

In addition to this our records showed that we, and an officer from the local Clinical Commissioning Group (CCG), had previously discussed staff shortages and similar issues with people's calls with the managing

director and the previous registered manager who had assured us and the CCG this problem had been addressed. This showed previous action taken to resolve staff shortages had not resolved this problem. This meant that despite people not always receiving their care and support when they should, there was a lack of effective systems in place to identify and improve this.

The registered manager told us they had a system using a client monitoring form for auditing people's files. We discussed one of the new client monitoring forms with an office based member of staff, which they had completed. They told us this was one of the first one they had completed and it had been a bit rushed. Some of the records we saw were incomplete. For example cash expenditure records kept for one person had several months missing. The section to check the cash records had not been completed on the cash records we saw to show the financial transactions had been checked to ensure they were correct.

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

The provider is legally required to notify us without delay of certain events that take place whilst a service is being provided. We found during the inspection there had been some events that took place which should have been reported to us that have not been. We found allegations of abuse towards a person who used the service had not been reported. We should also have been informed of any occasion where there had been an insufficient number of suitably qualified, skilled and experienced staff to provide the service.

This was a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

We received differing views from people who used the service and staff about the management of the service. As well as the comments we received from people who told us the service was not well led other people made positive comments about how the service was run. A person who used the service said, "I am happy with the way things are, it is well run." A staff member told us they felt the service was well led and that the registered manager was approachable. They said they were, "Encouraged to raise issues." Another staff member said, "If I have got an issue I can phone and ask for a meeting." They also said there was, "Good management."

Some people who used the service we spoke with told us they had completed a survey form they had been requested to. One person said they had completed the survey and they had, "Put my comments on." The managing director told us there had been a survey of people's views carried out in April 2015, however they told us due to the low volume of returns the survey was to be undertaken again so there was more meaning to the results.

We sat in customer services and observed staff ringing clients regarding staff changes and also documenting the calls on the Percurra IT system. We were shown the forms used in customer services to document how the unallocated calls were processed and this included how communication had been achieved.

The provider complied with the condition of their registration to have a registered manager in post to manage the service.

The registered manager said they held an open forum as well as formal client team meetings. These covered topics such as health and safety and training. The manager said notes were made of these and action plans prepared. There were also monthly newsletters sent out to staff. These displayed the company values and included details of new staff and any staff changes in position or role. There was recognition for staff who had been recognised as having, "Gone that extra mile." The managing director said when needed they also

sent out a staff bulletin.

The managing director showed us some work they were doing in response to issues raised in a staff survey to improve their working arrangements. This included reviewing the current arrangements for travelling time and payment of travelling costs.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person must notify the Commission without delay of any abuse or allegation of abuse in relation to a service user and an insufficient number of suitably qualified, skilled and experienced staff. Regulation 18 (2) (e) (g) (i)

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users must: deign care or treatment with a view to achieving service users' preferences and ensuring their needs are met. Regulation 9 (2) (b)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation. (16 1)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes must enable the

	registered person to assess, monitor and improve the quality and safety of the services provided and assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Regulation 17 2 (a) (b)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not a sufficient numbers of suitably qualified, competent, skilled and experienced staff. Regulation 18 (1)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes must be established and operated effectively to investigate immediately upon becoming aware of any allegation or evidence of such abuse. Regulation 13 (3)

The enforcement action we took:

A warning notice was issued