Penwith Care Ltd

Penwith Care

Inspection report

71 Fore Street
Hayle
Cornwall
TR27 4DX

Tel: 01736797909
Website: www.penwithcare.com

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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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was completed by one adult social care inspector on 18 and 19 April and 4 May 2016. The provider was given notice of the inspection in accordance with our current methodology for the inspection of domiciliary care agencies.

The service had previously been inspected in June 2015 when it was found to require improvement overall. Issues were identified within the Safe, Effective and Well Led domains. Two breaches of the regulations were identified in relation to staffing levels and staff induction, training and supervision. We found at this inspection that while some improvements had been made more needed to be done to improve the quality of the service provided.

Penwith Care is a domiciliary care agency which provides support to people in their own homes in and around St Ives Bay and Penzance. The service had doubled in size since our previous inspection and now supports approximately 60 predominantly older people in their own homes. Since our previous inspection the service had changed address.

The service generally provides short visits to support people to get up in the morning, to go to bed in the evening and to prepare meals during the day.

The organisation was led by a registered manager who also owns the business. 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 and associated Regulations about how the service is run.

At our previous inspection we found staff had not received an appropriate induction, staff training needs had not been met and staff had not received regular supervision. During this inspection we identified similar issues. The service had failed to follow its own induction training policy with respect to the Care Certificate and assessments of staff skills.

The training needs of the staff team had not been appropriately managed. The service used on line training materials to enable staff to access these materials when they wished. However, the service had failed to ensure all staff had completed the training the service policies had identified as necessary. In relation to moving and handling training one person told us, "They haven't had any personal training, it's all done on the internet, a lot of them don't know how to lift." While staff said, "I've had no training on how to handle people, how to roll people or things like that" and, "I have had no training and I do the hoist every day." Training records showed that of the 26 current staff; five had received no formal training, only eight staff had received manual handling training and 14 staff had received Health and safety training.

Staff did not understand local safeguarding procedures and only 14 staff had completed safeguarding training. Where significant incidents involving vulnerable adults had occurred the service had failed to make

timely referrals to the local authority

People told us, "They always come" and, "They have never missed a visit." During our review of call monitoring data and daily care records we found no evidence of planned care visits being missed. However peoples' feedback in relation to the length of care visits provided by staff was mixed; most people reported they did not feel rushed. However, one person told us they felt rushed and said their visits had been cut short. Staff comments about visit times revealed significant differences in approach dependent on the number of hours staff worked and the way in which they were deployed.

The service used a telephone based call monitoring system to ensure people received all of their planned care visits. People told us staff did not always use the call monitoring system and one member of staff said, "They all know how to scam it." We investigated this and found evidence that indicated staff had miss-recorded information via the call monitoring system. We discussed the time required to travel between these locations with the registered manager who agreed it was not possible to make this journey in the time recorded on the call monitoring system.

Accidents and incidents had not been appropriately documented. Where investigations had been completed they had not been sufficiently robust to establish what had actually happened.

People's care plans were up to date and provided staff with sufficient detailed guidance to enable them to meet people's care needs. People told us they got on well with their care staff and that their decision and choices were respected.

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

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. Some people were receiving shortened care visits and some staff had falsely recorded information about visit times in both daily care records and using the call monitoring system.

Staff did not understand local safeguarding procedures and the service had failed to make timely safeguarding referrals.

Although the service was short staffed, recruitment was ongoing and appropriate use of agency staff had ensured all planned care visits had been provided.

Is the service effective?

Requires Improvement

The service was not effective. The service had failed to follow its own policies in relation to the induction and training of new members of staff. The training needs of the existing staff team had not been appropriately managed.

There were systems in place to assess people's capacity to make decisions independently. Staff recognised the importance of enabling people to make choices about their care.

Is the service caring?

Good

The service was caring. People told us they got on well with their care staff and we observed staff providing support with compassion.

People's privacy and dignity was respected by staff. Staff involved people in decision making and respected people's choices.

People's concerns in relation to language barriers were being addressed by the registered manager.

Is the service responsive?

Good

The service was responsive. People's care plans were accurate and sufficiently detailed.

People knew how to make a complaint about the service and relatives told us that issues they had raised had been addressed and resolved.

Is the service well-led?

Requires Improvement

The service was not well led. Senior management were not entirely open during the first two days of the inspection process.

The registered manager had failed to ensure staff had received necessary training and had failed to properly investigate incidents and accidents.

Significant changes to the service's management structure were made during the inspection which was a further challenge to the provider.

Penwith Care

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 checked 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 18 and 19 April and 4 May 2016. The provider was given notice of the inspection in accordance with our current methodology for the inspection of domiciliary care agencies. The inspection team consisted of one inspector.

Before this inspection we reviewed information held about the service, previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we visited two people in their own homes and spoke with five other people and three relatives by telephone. We also spoke with 10 care staff, the provider's Human Resources consultant and the registered manager. In addition we also inspected a range of records. These included six care plans, four staff files, training records, staff duty rotas, call monitoring data, meeting minutes and service policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People told us, "They always come" and, "They have never missed a visit" and staff told us there had been no recent missed care visits. During our review of call monitoring information and daily care records we found no evidence of planned care visits having been missed.

On the third day of this inspection one person called the service's office to ask why their lunchtime carer had not arrived. Office staff identified that this visit was not on the rota for that day and managers took immediate action to ensure a care visit was provided. Subsequent investigation found this lunchtime visit had been cancelled by commissioners with the person's agreement and that this was the first day on which this visit had not been scheduled. The service's prompt response to the possibility of a care visit having been missed demonstrated there were appropriate procedures in place to ensure planned care visits were not missed.

People and their relatives provided mixed feedback of their experiences in relation to the timing of care visits. People's comments included, "The time of my visit does move. On Saturday they were an hour and a half late", "They normally arrive on time, never too early or too late" and, "Times do vary, they are usually here within half an hour." One person's relative told us, "I have spoken to them about times and things have been sorted out."

Staff recognised that their rotas sometimes included significant changes in planned visit times. Staff comments included, "One person is down for 10:15 on the rota but their visits are normally between 07:00 and 08:00", "We have to be at one person at 09:30 but we have not been getting there until 11:00 and [the person] really does not like that", "We are sometimes early but often late as the first two visits overrun a lot" and, "People are a bit cheesed off with us not sticking to the times." Staff also told us that their rotas did not always match with people's known preferences and one staff member told us, "We all twist our rota around to fit people in, we change it to how some people do it." Staff told us of one person who liked to go out for the day and was often not in when they arrived to provide the morning care visit if they were late. The registered manager was aware of some of these issues and told us, "We do have issues about times but we work with people so they can have the times they want."

People's feedback on their experiences in relation to the length of their planned care visits was again mixed. Some people told us, "They get everything done", "If there is more to do they will stay to help" and "You never feel like they are in a rush, you feel like they have come to see you and spend time with you." While one person's relative told us, "They have enough time and don't try to rush, They sit and wait to give [my relative] privacy." However, one person told us that they did feel rushed while receiving support from some members of staff. Their comments included, "Some staff want to get out before they get in, as they can be in such a rush" and "My morning visit is an hour, sometimes I have had them go in half an hour when they get called to go somewhere else."

A call monitoring system was used to monitor staff arrival and departure times from planned care visits for approximately half of the people who used the service. Staff used the person's own telephone to record their

arrival and departure time from the home by calling a free phone number.

We found there were significant differences in staffing arrangements and approach at Penwith Care. Some staff worked fixed part time hours each week and regularly visited a small number of people who they knew well. Where positive feedback was received about staff it was normally about this staff group. These staff told us, "I never rush because I like to chat with people" and "I feel like we have enough time with people. No, I do not rush." A second staff group, although on zero hour contracts, normally worked full time hours and provided care throughout the service's area. The experience and approach of these staff was significantly different. Staff comments included, "Some clients have 30 minutes but only take 10 minutes and they didn't have a clocking in box so you can catch up. You figure out who doesn't take long", "There are quite a few people who get short visits and stuff. But there are some people who need extra time so shorter visits are used so you can catch up eventually" and, "In the evening you don't always stay for the full time." This indicated there was an inconsistent approach to the delivery of care from the staff team leading to differences in people's experiences. Staff and people who used the service told us that some staff employed by Penwith Care had developed a method of miss-recording information via the call monitoring system. One person told us, "They don't always use the calling in system" and a staff member said; "You get left doing a double on your own because the other staff have gone to a different job", "Corners get cut all the time" and, "They all know how to scam it [the call monitoring system]."

We reviewed the service's call monitoring records and were able to identify occasions where staff had miss recorded information on the call monitoring system. We discussed these incidents with the registered manager who accepted the information recorded on the system was not accurate as the time needed to travel between individual homes was greater than that recorded on the call monitoring system. In addition, prior to our inspection health professionals had visited one person's home. They found there were no staff from Penwith Care present in the person's home at the time of their visit. The professionals reviewed this person's daily care records as part of their visit and found that information in the daily care records showed that the staff were present in the person's home at their time of arrival. Staff had recorded inaccurate information in this person's daily care records. This meant that people were not consistently receiving their planned care as staff were not providing care visits of the correct length.

This is a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not have appropriate systems for documenting, recording and investigating incidents that had occurred. Some accidents had been recorded in the service's accident book, others were recorded in communication records, while some incidents had not been formally recorded. Where accidents and incidents had occurred there was limited information available to demonstrate they had been effectively investigated. For example, a minor traffic collision had occurred while a member of care staff was transporting a person to the shops in their car. This incident was recorded in the person's communication records but no accident reports had been completed.

Managers were aware of changes to local safeguarding procedures and team meeting minutes showed that this information had been shared with staff. However, the service had failed to make timely referrals to the local authority when significant incidents had been reported. Training records showed only 14 of the service's 26 staff had received safeguarding training and when asked staff were unable to explain local procedures for the safeguarding of vulnerable adults.

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

2014.

During our previous inspection we found that recruitment processes were not sufficiently robust and Disclosure and Barring Service (DBS) checks had not always been completed before staff were permitted to provide care and support. At this inspection we found that the service's recruitment processes had improved. Prospective staff members had been interviewed and their identity confirmed as part of the recruitment processes. References had been requested and DBS checks completed before new staff provided care visits.

On the last day of our inspection we looked specifically at staffing levels. The service employed 26 care staff to provide over 800 hours of care each week. Two members of staff were on long term sick leave and two were on extended periods of leave. One staff member told us they had been due to be on leave but had been asked to provide early morning care visits during their leave. Another staff member commented, "I thought there was enough staff but there is a big turnover." We found there were not enough staff available to provide all of the planned care visits for the last day of our inspection and for the next two days. The registered manager had identified this shortage and had made arrangements for agency staff to be used to ensure all planned visits were provided. Staff told us, "They are taking on more staff at the moment." The service was actively recruiting and in the process of appointing two new members of staff at the time of our inspection. The registered manager told us, "I do not have to go on shift now." We found there were enough staff available with limited support from agency staff to ensure all planned care visits were provided.

Each of the care plans we inspected included risk assessment documents. These assessments identified sources of risk to both the person and their staff during care and support visits. Staff were provided with guidance on the actions they must take to protect people from identified areas of risk. These documents were found to be excessively long and it was questionable as to how these documents could be read and fully understood by staff during their short visits to people's homes.

There were procedures in place to ensure people's care visits were provided during times of adverse weather. The staff team lived throughout the area in which people were supported and a four wheel drive vehicle was available for staff transportation if required.

The service supported people to manage their medicines by prompting or reminding the person to take their medicines. Where staff supported people with medicines from a blister pack prepared by a pharmacist, they recorded in the daily care records the number of tablets the person had taken.

The service had appropriate infection control policies in place. Personal protective equipment including disposable gloves and aprons was readily available from the service's office and staff regularly visited the service's office to collect these items. During our visits to people's homes we saw that staff used appropriate personal protective equipment while providing people with support.

Requires Improvement

Is the service effective?

Our findings

During our previous inspection in June 2015 we found that the service's systems for the induction and training of new members of staff was inappropriate, established staff had not received training in accordance with the service's policies and staff had not received regular supervision. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we again reviewed the service's induction and training policies. The induction policy stated; "The service has a "Safe to Leave" policy based on CQC guidance. It recognises that staff need close supervision and support throughout the induction period. Before any new staff member is allowed to work on their own or with relatively inexperienced colleagues the service carries out a full assessment of their competence to do so, which includes an assessment of any risks arising as a result of their working unsupervised." We asked to see evidence to demonstrate these assessments of competence had been completed. The service was unable to provide this evidence. Our review of staff training records again demonstrated that the service had accepted and included training certificates for courses completed during a staff member's previous role without having assessed the staff member's current skills.

We were informed that all new members of staff received a one day induction to the service. This included reviewing and signing the service's key policies and an explanation of safeguarding procedures. We found that a number of recently recruited staff had not signed to state that they had read the service's policy documents.

The service's staff training policy stated, "All new members of staff, who are also new to care work, receive induction training that should result in their being awarded a Care Certificate that will allow them to work without being directly supervised. This training is completed within 12 weeks of their starting work." We reviewed the training records for a number of recently recruited members of staff. These records showed staff had not completed the Care Certificate in accordance with the service's training policy. For example, two staff who had joined the service in January 2016 had not completed any of the 15 sections of the Care Certificate by the time of our inspection.

One person told us, "They haven't had any personal training, it's all done on the internet, a lot of them don't know how to lift." While staff said, "I've had no training on how to handle people, how to roll people or things like that", "I have been shown things while shadowing but I have not had any training, no" and, "I have had no training and I do the hoist every day." In relation to the online training materials one staff member told us, "I haven't actually done them yet."

The service used online training materials to enable staff to complete training at their own pace. However, the registered manager had failed to monitor the training completed by staff and we found that a number of recently recruited staff had not received or completed the training necessary to ensure they had appropriate skills to meet people's care needs. Our review of staff files and the service's training records found that of the 26 care staff employed by the service at the time of our inspection five had not completed any formal training and one staff member was not recorded on the service's training records. Our analysis of the

service's training records found that of the 26 care staff, eight had received manual handling training, six had received food hygiene training, 13 had received infection control training and 13 staff had received training in health and safety. In summary there was a failure to provide staff with an appropriate induction, to assess staff competence and to ensure staff received regular training. This was an ongoing breach of the requirements of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff initially worked alongside a more experienced staff member to observe and learn from their practice. The length of this period of shadowing was flexible and depended on the individual staff member's previous experience and confidence levels. Staff confirmed this was correct and told us, "I was shadowing for the first two days, then I had half a day in the office looking at the policies. Then I was doing singles", "I was shadowing for four or five days", "I was shadowing for the first two weeks then went through the policies and signed and discussed them. It took about three hours" and, "I did a couple of shadowing shifts before I started."

Staff supervision was provided by the services' human resources consultant and the registered manager while spot checks were completed by the service's two senior carers. Records showed some staff had received supervision and/or a spot check since our previous inspection and that staff meetings had been held more regularly. Staff told us, "We get spot checks that can happen at any time, I have had a spot check" and, "We quite regularly have team meetings we had one in Carbis Bay the other week." However, two staff told us they had, "never had a spot check." Of the four staff whose files were reviewed in detail three had received recent supervision.

None of the staff whose records we reviewed had been employed for more than one year. We discussed the service's annual appraisal system with the registered manager who told us, "Appraisals are being introduced for staff who have done more than 12 months service." The introduction of an annual appraisal system with ensure staff receive formal feedback of their performance and provide an opportunity for individual goals to be discussed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The registered manager had some understanding of the requirements of the Act and there were systems in place to assess people's capacity to make decisions independently. People's care plans clearly directed staff to respect people's decisions and choices.

People's care plans included guidance on the support people needed with meal preparation. For example, one person's care plans for their tea time visit said, "Ask me what I would like to eat and drink for tea. It will generally be something light, I would like you to give me choices."

We visited two people at home during visits where staff were supporting people to prepare their evening meals. Staff asked people what they wished to eat for their meal and involved people in these decision making processes. For example, one person asked for a prepared meal from their fridge. Staff found there were two meals available and brought both options to the person so they could choose which they preferred for that evening. However, one person told us that staff required additional training in food preparation and described an incident where staff had used inappropriate methods to prepare a light snack. Our review of staff training records showed that only six of the 26 staff had received food hygiene training.

The service worked with local health professionals to ensure people's care needs were met. Where staff

identified concerns during care visits this information was passed to the registered manager who sought guidance from health professionals appropriately. Details of any guidance provided was recorded in the service's communication records and promptly passed to care staff.

Since our previous inspection the service had relocated to a new office location on the main street of Hayle. This location was a significant improvement over the service's previous facilities as it included a training, or meeting room, and desk space for three office based staff. An additional computer was available in the training room to enable staff to access on line training materials.

Good

Is the service caring?

Our findings

Most people were complimentary of their care staff and told us, "I am very pleased overall", "all the girls are quite nice", "the staff are absolutely smashing, friendly and professional" and "the carers have looked after me very well." Although people had raised concerns about the delivery of support their comments about staff were positive. For example, "generally they try to do as much as they can for me" and, "the carers have been ok at the moment and have done what I needed them to do." People's relatives all spoke highly of staff. Their comments included, "[The staff] are very courteous and reliable", "I would say they are very good, chatty, helpful and polite, they have been great", "[My relative] refers to them as his angels, I think they are fantastic very reliable and very caring" and, "My relative gets on very well with the staff."

Staff told us they enjoyed the company of the people they supported and said, "I get the most pleasure out of doing this job, I love it actually", "I am really enjoying it" and, "I have the same clients each week so they have gotten to know me." People and their relatives told us they got on well with their staff. Relatives told us, "They say hello when they come in and pay a lot of attention to [my relative]", "They are very good they get on well with [my relative]" and, "they do listen to what we are saying, they are good in that respect. They are easy to deal with."

During our visits to people's homes we saw warm and positive interactions between staff and the person they were supporting. Staff greeted people with genuine affection and ensured they were on the person's eye level while sharing information. Staff chatted pleasantly with people about how they had spent their day and provided care with reassurance and compassion.

People told us staff respected their decisions and choices. Comments included, "They do everything that I ask", "I am able to choose, that is not a problem" and, "They do what I want". Staff demonstrated a good understanding of the importance of respecting people's choices and dignity. Staff told us, "It's just a natural thing to do, I ask people what they want", "I do close the curtains for people before providing personal care" and, "You are in their house and you have to respect that and leave it tidy." One staff member described how they had helped and supported one person to move some furniture to a position that appeared to them inconvenient. This staff member said, "It's their home and the way they want to live. So if it does not cause harm why not. It's not for me to tell people what to do."

Not everyone who worked at Penwith Care had English as their first language. Some people told us that they sometimes found it difficult to understand what staff were telling them during care visits. People's comments included, "The language can be a problem with some of the girls" and, "With some of the others it can be difficult to understand what they are asking." We discussed this with the registered manager who explained that in future the service's rotas would ensure that staff whose first language was not English did not work together to provide support for people who required two carers to meet their care needs. This meant people would always be able to communicate effectively with at least one carer to explain what their needs were and describe any changes in their health.

Good

Is the service responsive?

Our findings

People's care plans were developed from information provided by the care commissioners combined with details gathered from the person during an assessment visit and staff experience during their initial care visits to the person's home. One person told us, "The manager came to see me to do an assessment when I started to find out what I needed". While staff said, "We are involved in updating them [care plans] as we actually know the people better than staff from the office. The initial care plan is updated after the first two weeks of us visiting."

We visited two people at home as part of the inspection process and found that care plans, risk assessments and a copy of the service's user guide were present in each person's home.
Each person's care plan included information for staff on how to access the property, details of the person's current health needs, information about the support they required with meal preparation and the management of medicines. For each planned care visit staff were provided with clear, step by step guidance on the care and support the person normally required. In addition care plans reminded staff to respect people's decisions and choices. For example one person's care plan stated, "I will wash myself, however I will need you to support me in areas I can't wash. I am able to express my needs." While another care plan said, "I will need some support whilst in the shower but I will say what help I need."

People were aware of their care plans and one person told us, "I have read the care plan and it is up to date". Relatives said, "I set out the care plans and they follow it through" and, "The care plan does have enough information for staff to know what to do." Staff told us, "They are good up to date care plans" and, "The care plans are usually pretty detailed with information about people's particular likes and dislikes."

People's care plans had been regularly reviewed and updated to ensure they accurately reflected people's current care and support needs. However, one of the care plan's we reviewed did not reflect the care provided by staff. This person's care plan instructed staff to support the person to have a shower every morning. This person's daily records showed that staff had not supported this person to shower each day and instead had provided a full body wash. We discussed this person's current needs with the registered manager who explained that they had become increasingly frail and no longer wished to shower each day. The registered manager told us the care plan would be updated to reflect this change.

One person did not have a formal care plan, instead that service had adopted information provided by the person's relative who was present during all care visits and directly oversaw the care and support staff provided. We spoke with this relative who was happy with the care and support provided by the small, consistent staff team. This showed there was flexibility within the systems to help ensure arrangements suited the individuals needs and preferences. Daily records were completed by staff at the end of each care visit. These recorded details of the care provided, food and drinks the person had consumed as well as information about any observed changes to the person's needs. The daily care records were signed by each member of staff present at the care visit. People were aware these records were completed during each visit and relatives told us, "The daily records are a set little thing that they write at each visit, they use the same phrases. For example, All well on leaving" and "The notes record what they have done and anything they

have noticed that has changed. If [my relative's] skin was red or something they would record that they had put some cream on it."

The service responded appropriately to changes in people's care and support needs. Communication records showed that where staff had identified that people needed additional support this information had been shared promptly with commissioners. One staff member told us; "Sometimes new clients have maybe 30 minutes in the morning to start the day and have a wash. But if we realise this is not enough time we tell the manager and she reports it to the council. Then it gets increased to say 45 minutes. This happened two weeks ago with a new client"

The service had a formal complaints policy. People and their relative's told us they knew how to make complaints about the service. One person's relative told us the manager had addressed and resolved an issue that they had recently reported.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in June 2015 the service was in the process of making significant changes to its management structure. A deputy manager had recently left the service and a human resources (HR) consultant had been retained to provide support with staff management and training on a three days per week basis.

During this inspection the service's management team was again significantly altered. At the beginning of the inspection the registered manager was working full time in the service's office. The HR consultant was continuing to provide support two days per week while the service's accountant was working within the service two days per week to address and resolve contractual issues with commissioners. Two senior carers spent up to half of their working time in the service's offices. One senior carer worked with the registered manager to develop staff rotas while the other senior carer focused on reviewing and updating people's care plans during her office hours.

Shortly after the first two days of this inspection the HR consultant left the service. As a result the management team was restructured and the service's accountant took on additional leadership responsibilities working in the service three days per week. One of the senior carers had been moved into the office on a full time basis and had been given responsibilities for managing staff training as well as reviewing and updating people's care plans. This meant the service was again experiencing significant managerial challenges at the time of our inspection. Staff told us, "The managers keep changing, they haven't been consistent but the registered manager is very hands on" and, "I think they are very good but they could be more organised."

During the initial two days of the inspection the management team's approach to the inspection process was not consistently open and transparent. For example, when specifically asked for information about significant accidents and incidents that had occurred, the management team failed to provide the requested information.

In addition, we found investigations into accidents and incidents had not been sufficiently robust. For example, the investigation into the incident where staff were not present in a person's home during a visit by health professionals had failed to establish where the staff were at the time of the incident. The registered manager told us that the staff claimed to have accidently miss-recorded the hour when the care visit had been provided and that the visit had been provided earlier than planned. This explanation had been accepted by the registered manager and limited disciplinary action had been taken. We reviewed daily care records and call monitoring information for the two staff involved in this incident. This analysis found that it would not have been possible for the staff to have visited before the planned visit time as both staff had full visit schedules and had worked with other staff members during part of their morning care shift. The service's investigation into this incident had failed to conduct this analysis or adequately test the explanation offered by staff.

Prior to the inspection we received information of concern in relation to a significant incident. The

commission had contacted the service and requested that they provide copies of relevant documents about this person's care. The information subsequently provided contained two documents, both of which had been completed by the registered manager and were directly contradictory. This demonstrated that the service's systems for investigating accidents and incidents were not sufficiently robust.

Staff visit schedules had not been completed on a weekly basis for a number of weeks prior to our inspection as the senior carer who normally developed staff rotas had been on leave. Some people reported that they had had not recently been supported by a consistent staff team and one person told us they had been visited by "six or eight different staff" in a single week. Staff told us, "I don't have my rota for tomorrow yet, the last few weeks have been like this" and "Just recently it has been changing a lot, in the last two weeks or so. Every week we were getting a rota for the whole week but not anymore". One staff member told us, "Last week I had seven different versions of the rota." We found that staff had not been provided with complete rotas for either of the weeks of our inspection. The registered manager told us, "We aim to send out the rota on Friday. Sometimes Saturday or Sunday morning. I know it's not ideal" and, "The rota is not normally for three days." The lack of well organised staff rotas and numerous changes reported by staff, meant people were at increased risk of planned care visits being missed.

Some improvements had been made to quality assurance processes since our previous inspection. For example, daily care records were returned to the service's office more regularly and had been reviewed to identify any areas of concern. However, information from daily care records had not been cross referenced with call monitoring data or compared with information within people's daily care records. During our analysis of the daily records we found an example where a member of staff had recorded that they had departed from a person's care visit at 10:10 and arrived at their next care visit at 10:00. The service's quality assurance system had also failed to identify the significant issue described in the safe section of this report where staff had used the service's call monitoring system to miss record their time of departure for care visits. This meant these quality assurance systems were insufficiently robust to protect people from this significant areas of risk.

In addition the registered manager had not exercised sufficient oversight of staff responsible for managing staff training needs and investigating significant incidents. We found current governance arrangements were ineffective.

This is a breach of the requirements of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff respected the registered manager's commitment to the service and told us they were always able to access support from on call duty managers when required. Staff comments included; "The manager is a very nice lady, If I have any problems or questions I can ring up for any support that I need" and, "[The registered manager] really cares about people."

Shortly before our inspection the service had sent out a survey questionnaire to obtain feedback on their performance. Initial responses received were positive with comments including, "[My relative] is very satisfied with the care and attention of your carers and is very happy with the way things are going." The registered manager told us, "things are pretty good at the moment, we are receiving positive feedback."

Since our previous inspection the registered manager had not progressed further with the completion of their level five diploma training. However, following feedback at the end of the first two days of inspection and changes within the management team, both the registered manager and one of the senior cares enrolled to complete this training.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to make timely safeguarding referrals and ensure staff understood local safeguarding procedures is a breach of regulation 12.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The failure to ensure people received care visit of the correct visit length is a breach of regulation 9.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The on going failure to provide staff with an appropriate induction, to assess staff competence and to ensure staff received regular training is a breach of regulation 18.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The failure to exercise sufficient oversight of staff responsible for managing training needs or investigating significant incidents combined with the disorganised visit scheduling system and the failure to identify that staff were miss recording information about visit time demonstrated that governance arrangements were ineffective and in breach of regulation 17.

The enforcement action we took:

Warning Notice