Tailored Care Limited

Tailored Care Ltd

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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

Our inspection took place on 24, 25 and 31 January 2017 and was announced. We gave the provider notice of our visit because the location provides domiciliary care and we needed to make sure there would be someone in the office at the time of our visit. We last inspected the service on 8 September 2016. The service was rated as "Good" overall following that inspection.

Tailored Care Ltd provides personal care for people in their own homes. At the time of the inspection there were 59 people using the service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that people were supported by insufficient numbers of staff resulting in missed and late calls, and poor care. As a result of missed calls some people did not receive the medicines or food they needed to support their health and wellbeing at the correct times.

People had risk assessments in their care plans to guide staff on how to reduce risk. However, this guidance was not always detailed enough to provide staff with full and clear guidance. Risk assessments where not always adhered to, for example, in terms of how many staff needed to be involved in certain aspects of people's care.

Guidance around when people required topical cream to be applied to keep their skin healthy was not always available to staff.

Staff were recruited safely, although we found an example of former employer references not being pursued by the provider. Staff were subject to police checks prior to starting their employment. Staff were clear about their responsibility to report matters of potential abuse.

While staff received regular training, staff told us the initial training new staff received was not always adequate. Some people and staff told us newer members of staff were not appropriately trained. People and staff were more positive about established staff's abilities and the continuing mandatory training they undertook. Staff worked towards a recognised care qualification.

Not all complaints were processed appropriately under the provider's complaints process. Some people told us they had not received feedback on issues they had raised or resolutions to problems. We saw the provider had completed surveys with people. We found not all issues raised by people during the survey had been actioned by the provider.

Most people felt the service was poorly run and that there were many areas where the management required improvement. Staff told us the culture at the service was negative and staff felt stressed and over worked.

People told us they did not always receive support from a consistent group of staff. People and staff reported a high staff turnover due to poor morale. We found the provider was in the process of recruiting new members of staff.

We found that safeguarding referrals had not always been shared with the registered manager by branch staff. Some issues raised by people with the branch manager had not always been shared with the registered manager or other relevant agencies, such as the CQC.

The provider had put in place appropriate audit systems and policies which would allow them to see where issues and challenges lay within the service. However, these audits had not been appropriately applied and were not, therefore, effective at identifying issues which impacted on people's care.

Some people reported meals were missed or late due to late or missed calls. Staff knew about people's dietary needs and preferences, and records provided guidance on people's needs in respect of food and drink. Staff supported people to access healthcare professionals as required.

People were positive about staff who directly provided their care in terms of their level of compassion and caring. However, people told us the provider did not provide a caring service overall.

People were involved in the assessment and planning of their care. People or their representatives had signed most care records to show their understanding and consent of the contents of records. Staff promoted people's dignity, privacy and independence. Most care records were written in a person centred way, which emphasised people's independence.

The registered manager and staff knew how to support people's choices appropriately and in line with legislation.

We found matters which amounted to breaches of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

We found there were not enough staff to support people with their needs, resulting in missed and late calls.

People did not always receive their medicines at the correct time in order to support their health.

Matters of concern had not always been dealt with in line with guidance and legislation.

Staff were clear about their duty to report matters of potential abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People and staff reflected that training for new staff was sometimes inadequate leading to staff who were not skilled in their roles.

People did not always receive the food they required due to late and missed calls. Staff were aware of people's food preferences.

People were supported to make decisions about their care in line with legislation.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The provider did not support people in a caring way.

People were treated by individual care staff with care and respect.

Staff respected people's dignity and privacy, and promoted people's independence.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

There was a complaints policy in place which enabled people to raise issues of concern, but this was not always followed in dealing with people's concerns.

The provider sought people's feedback via a recent survey, but action had not always been taken where people highlighted issues.

Staff demonstrated an understanding of people's changing needs.

Is the service well-led?

Inadequate

The service was not well-led.

Most people and staff told us they felt the service was poorly managed.

People told us they received an inconsistent service, resulting in issues such as missed and late calls.

Audit systems were in place, but they had not been effective in identifying and addressing issues regarding the quality of care people were receiving.

Tailored Care Ltd

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.

We carried out a responsive inspection due to information of concern from members of the public and whistle blowers which related to the quality of care being provided by the service.

This inspection took place on 24, 25 and 31 January 2017 and was announced. The provider was given notice because the location provides a domiciliary care service and we needed to be sure that people would be available to talk with us.

The inspection was carried out by an inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was people who have a physical and/or sensory impairment.

We looked at information we held about the service. This included statutory notifications which are notifications the provider must send to inform us about certain events, such as injuries. We looked at the information we had received from the representatives of people who used the service and whistle blowers. We also contacted the local authority and other relevant agencies for information they held about the service. We used this information to help us plan the inspection.

We spoke with seven people who used the service and eight relatives. We also spoke with three care staff, the branch manager, the registered manager, the quality and performance manager and the responsible individual who was also one of the provider's directors. We looked at seven people's care records, records relating to the management of the service, records relating to health and safety and three staff files.

Inadequate

Is the service safe?

Our findings

People's relatives and whistle blowers made us aware of a number of issues around there being insufficient numbers of staff to care for people. It was reported to us this had resulted in a number of people experiencing missed and late calls.

We asked people about this. Many of the people we spoke with confirmed they had experienced a number of missed and late calls which had impacted on them. A person told us, "They keep leaving; they don't know whether they are coming or going, the rotas are being altered all the time". One relative told us, "[Person's name] has tried to dress [themselves] when the carers have been late and we are worried [person's name] is going to fall again…But the carers are due at 8am and once didn't come until 1.45pm". Another relative told us, "They seem so stretched, they are run ragged". A further relative told us, "Occasionally they seem stressed and tired, so I don't think there are enough carers". Another relative told us, "They are often late and so tired which I think can be dangerous. They are working until midnight and starting at 6am. It isn't right". One person told us, "From Christmas and before. It's so hit and miss...it isn't the girls' fault. I feel sorry for them really". Another relative told us, "Quite a lot, especially at the moment". A further relative said, "Yes lots, too many".

People and relatives gave us examples of how late or missed calls had impacted on care. For example, one relative described how a person had diabetic care needs which included the need for medication and regular mealtimes. They told us medicines and food were sometimes provided late or not at all if staff missed the call. Other people told us late calls affected mealtimes, so they were not hungry when a previous meal had been provided later than agreed. This meant late or missed calls were placing people's well-being at risk.

We asked staff about staffing levels and how this affected their roles. Most of the staff we spoke with told us their ability to complete calls with people had suffered as a result of short staffing, being given additional calls while already on duty and lack of travel time between people's homes. One staff member told us, "We're rushed and make mistakes" and "We may not complete the full time of the call". Some staff told us this resulted in people being supported by a single member of staff, while their risk assessment showed they required two staff to be safe. One example of this was where a single staff member told us they had been directed by branch management to assist someone to move. The person required the assistance of two staff to ensure their safety. Some staff told us they would often start work at 6am and not finish until midnight, due to the pressures they were under. They told us this left them tired and less able to provide the quality of care they would like. This meant that people's safety and wellbeing was compromised by a lack of staff.

We asked the provider how they assessed staffing requirements. They explained that staff numbers were calculated on the basis of how many people were receiving care and what people's needs were, such as how many people required two care staff. However, this had not prevented issues with late or missed calls due to, for example, staff illness.

We asked people if they were supported by staff with the medicines they required to promote their health.

Most people we spoke with were not supported with medicines. However, the relative of one person told us they were. They explained missed and late calls were affecting the person receiving their medicines at the prescribed times. They told us, "[Person's name] takes medicines in the morning and this is more reason that we need the care to be on time because it is risky when they are late. [Person's name] forgets to take her medicine".

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

We asked people and their relatives if they felt the care offered was safe. We received a mixed response. One relative told us, "Some of them, some have experience and seem well trained, but they have a lot of young people coming in that have no idea whatsoever". Another relative told us, "Yes, when they turn up". Other people were more positive about their experience. One person told us, "Yes, they work as a team" and "I don't always feel safe when they use the sliding sheet, but there have never been any accidents". Another person told us, "Yes, they are all very good and trust worthy". This meant people did not always feel safe with staff.
Risks to people had mostly been assessed and there was some guidance for staff on how to manage these risks. However, some risk assessments required more detailed plans for staff to refer to about how to care for people in a safe way. For example, two people's risk assessments had not been updated to ensure they were being moved in a safe way. This included how one person needed to be supported in order to be safely transferred from a wheelchair to a bed.

We spoke with staff and, while they were aware of the need to reduce risks and how this could be achieved, they told us the pressure of the amount of calls they had meant that guidance was not always adhered to. For example, people who required assistance to move around their home had completed risk assessments which detailed how this should be carried out safely. However, staff told us they were sometimes working as single staff, when risk assessments dictated two staff should be employed to reduce risk. This meant that, while risk was considered, the guidance was not always applied in order to keep people safe.

We looked at people's medicines records. We saw some people required prescribed creams, from time to time, in order to keep their skin healthy. We saw there was a lack of guidance for staff about when, where and how these creams should be used. Staff told us, and records showed they received update training in respect of medicines.

We looked at how staff were recruited. We saw that the provider took steps to ensure that staff were appropriately assessed as being suitable and skilled people to work in care prior to their recruitment. We saw staff were subject to police checks to ensure they were of good character. Staff confirmed these checks had been completed prior to them commencing their role. We found references had been sought for most staff. We did however find the references for one member of staff had not been obtained from their last two employers. Their file offered no explanation as to why this had occurred. We raised this with the registered manager, who said they would take appropriate action in respect of this. This meant most staff had undergone checks prior to starting work.

We asked staff about how they protected people from potential abuse. Staff were clear about their duty to report matters of abuse. They were also able to reflect what external agencies they could report matters to. Staff we spoke with could describe the signs of abuse. We found a number of staff had reported issues of concern to the CQC and local safeguarding authorities. This meant that staff knew what action to take to protect people from harm.

Requires Improvement

Is the service effective?

Our findings

We asked people if they felt staff were trained, skilled and able to meet their needs. We received a mixed response. One person said, "Yes and no, the majority of the time yes". Another person told us, "I don't know [some staff] haven't done it before, they don't get the training. They may shadow once then have to do it by themselves and you have to explain everything to them over and over again". One relative told us, "Not all of them". Another relative told us, "They haven't got a clue". A third relative said, "No, quite often we have people who haven't shadowed". This meant some people were not being supported by staff who were skilled and knowledgeable in the areas of care they required.

We asked staff about their experience of the induction process and training with the service. We received differing views on the effectiveness of the training. All staff told us that they received a three full day induction training, which included areas of care such as catheter care and moving and handling (including the use of hoists). Staff also told us they received 16 hours of shadowing experienced members of staff. Staff training records confirmed they received training in all important areas of care. However, two out of three staff we spoke with felt the initial training could be longer and more in depth. One staff member told us there was pressure for staff to get through the training and shadowing process, as this was unpaid. They also reflected that, while they found the three day training to be adequate for them; other staff members did not appear to find this sufficient training. They told us, "They rush new staff through…sometimes they haven't got a clue". This meant initial training for staff was not always adequate.

We saw the provider had identified a number of subject areas for core training and update training for staff. These included areas such as moving and handling and safeguarding people. The provider maintained a training chart to show who had received updated training. The chart showed that most staff were up to date. We saw staff completing the Care Certificate. This is a nationally recognised certificate for those working in care. It showed that staff who had completed it have been assessed in important areas of care. This meant that on going training for established members of staff was in place to ensure they remained updated.

Prior to our inspection we received reports that some people missed mealtimes or received their meals late. During our inspection one person told us, while staff offered them choice in food and drink, "I am a diabetic so can only eat at certain times, which they know, but sometimes come too early or too late". A relative told us another person with diabetic care needs would receive their meal late or not at all. Another relative told us, "[Person's name] isn't happy with the service. They are coming late for breakfast, sometimes at 11am, then they are on time for lunch at 12.30pm but [person's name] isn't hungry then". This meant some people were not receiving the support they needed to maintain a balanced diet. People were positive about the way in which staff supported them with food and drink when staff were present for agreed mealtimes. Staff we spoke with showed knowledge of people's dietary needs and preferences. People's care records provided guidance to staff about people's food and drink preferences.

People we spoke with were able to make decisions about their care, or were able to make the decision to pass care decisions to their representatives. We spoke with the registered manager and staff about how they ensured people's rights were supported in respect of decisions about their care. We found that staff had

knowledge of the Mental Capacity Act and how this might impact on people and what steps they should take if this were the case. 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 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 and their relatives told us care staff supported them to contact external healthcare professionals when needed. One relative described how staff had suggested a piece of equipment which might assist the person to move about. The staff member ensured this equipment was ordered. Another relative described how staff had supported a person following a fall, including calling the ambulance service. Relatives also told us staff would communicate with them if they had concerns about a person's health or wellbeing. One relative told us, "They tell us if there is a problem. Once [person's name's] legs were red and they told us and the district nurse". Records showed staff took action where necessary to support people's health. This included noting areas of sore skin and taking action in relation to these concerns. Staff were clear about their responsibilities to report matters of concern about people's health to the office, so action could be taken. This meant staff supported people with their healthcare needs as necessary.

Requires Improvement

Is the service caring?

Our findings

People and relatives we spoke with told us staff who directly provided care were compassionate and caring. People told us, "The girls are very good, kind and ask me if I need anything before they go"; "Yes, they help me if I need it" and "They are polite and aren't rough. They always ask about how I am; have a joke and make me feel good". Relatives told us, "They are always caring" and "They are nice girls. I can talk to them; they are friendly". However, despite people being positive about the staff who directly supported them, they told us the provider did not offer a consistently caring service overall. For example, people told us they had raised issues with the service's office about missed and late calls, among other issues. A number of people told us these issues had not been resolved or responded to in an appropriate way. People told us they found the management team were sometimes negative when they raised matters with them, or when they spoke with the office. This meant people did not receive a consistently caring service from the provider.

Most people we spoke with told us they were involved in planning their care. One person told us, "Yes I am involved". A relative told us, "Yes more or less. I am involved. We get help with what we need. We saw staff had carried out assessments of people's care and reviewed this. We saw in care records that, where needs or preferences had changed, these had been updated. We saw that people or their representatives had signed most care records to show their understanding and consent to their contents. This meant that people were involved in the assessment and planning of their care.

People told us staff respected their dignity and privacy. One person told us, "Very well, they shut the door when people are around" Another person told us, "I think it is okay". Another person said, "They always ask if I need help with personal care and they respect my decisions". A relative told us, "Brilliant; they wash him in the kitchen; pull the blinds down". Staff gave examples of how they supported people's privacy and dignity, for example, ensuring people were as covered up as much as possible during personal care and ensuring doors and curtains were closed at appropriate times. We found the provider had implemented a confidentiality policy. Staff were aware of their duty to keep matters relating to people private.

People were positive about how staff promoted their independence. One person told us, "I do as much as I can for myself". Another person said, "I tell them what I want to do". A relative told us, "[Person's name] is quite independent at getting around. They only ask what we can't manage to do". Staff were clear about how they promoted people's independence and gave examples of how they supported people to carry out personal care tasks for themselves, where possible. We found that records positively expressed what people were able to do for themselves, as well as areas they needed support with.

Requires Improvement

Is the service responsive?

Our findings

We asked people if they were supported by a regular group of care staff who knew their needs and preferences. We received a mixed response. One person told us, "Not as regular as I would like. I get a lot of 'shadowers' [new members of staff who were observing care]". Another person told us, "No, I never know who is going to walk through the door". A third person told us, "Yes and no. I would love regular carers. You get used to certain carers then they disappear". One relative told us, "Yes, when they turn up". Another relative told us, "They are not always the same ones, it changes week to week". A third relative said, "No, this is a problem as well. It is someone different every time. We have also complained about that". This meant staff were not always familiar with people's needs and preferences. However, people's care plans were individualised and provided guidance to staff on people's preferences, beliefs and wishes. We spoke with staff who confirmed they had access to people's care plans in people's homes. This meant, although guidance was available, people felt staff were not always familiar with the contents of their care plan.

We asked people if the provider dealt with complaints in an appropriate way. We received a mixed response. One person told us, "I've complained about the timekeeping; they haven't sorted it out". A relative told us, "I complained to the council about the times and how long they stay. I am not happy is hasn't been sorted out". Another relative told us, "I have complained about timings. I get promised phone calls that never happen. So I request to speak to someone higher then just get sent back to [the branch manager] because apparently [they] can deal with it, but isn't". Some people told us issues had been addressed, such as care staff being changed when they requested it. However, we found complaints were not always being processed in line with the provider's complaints process, or issues addressed properly. This included the poor completion of the necessary complaint process forms. This was despite the provider having highlighted the importance of adopting a proactive approach to complaints in a communication dated September 2016 to the branch manager and registered manager. This meant the service did not consistently follow their own complaints procedure, or provide an effective response to people's complaints.

We asked people whether the provider routinely sought their opinions on the service. We received a mixed response. While some people recalled receiving a survey from the provider seeking their views other people told us the provider had not sought their opinion on the running of the service. We saw the provider had gathered surveys from people and their relatives. The provider showed us surveys some people had completed dating to October 2016. We saw some people had raised concerns as part of their survey responses. These included issues which we had spoken with people about which they reported had not been resolved to date, for example; late and missed calls.

We asked the quality and performance manager how issues raised by people during the survey had been dealt with. We were told a staff member had phoned the relevant people to acknowledge their concerns. However, we found some of these issues had not been addressed. This included continuing issues with how the office responded to people who telephoned in for assistance, calls times and issues specific to one person's care. This meant, although people's opinions had been sought and some issues dealt with, there was evidence the provider had not dealt with a number of issues raised in a satisfactory way.

People and their relatives were involved in the planning of their care and support. Most people were positive about how they were enabled to participate in the planning of their care. One person told us, "I do tell them what I need". Another person said, "They just ask". A relative told us, "All the information is in the folder". People told us care staff communicated well with them. One relative told us, "Oh yes, when they are going to do something, they explain it and repeat it if [person's name] doesn't understand first time with their dementia". This meant care staff maintained effective communications.

We saw most care records were written in a person centred way and detailed what people's aims and goals were in connection with the care they received. For example, this included staying safe and maintaining as much independence as possible. Care records were reviewed. We saw that people, or their representatives had signed most, but not all care records. This was to show their knowledge and involvement with these records, in addition to their consent of the contents. This meant care records largely provided updated guidance to staff, although people did not always experience care which met their needs due to other factors.

Inadequate

Is the service well-led?

Our findings

We received information prior to our inspection which suggested the service was being poorly managed. This included the poor coordination of rotas and a failure to respond to issues of concern from people, their relatives and staff. We asked people if they felt the service was well managed. Most people told us they felt the service was poorly managed. When we asked if the service makes improvements one relative responded, "Oh god no", another told us, "Nothing has changed in the past nine months". A third relative told us, "No, certainly not".

We asked people how they felt the management of the service could be improved. One person told us, "If they were on time". A relative told us, "Lots of ways. The carers are so tired, lots of driving about, they finish late. The way the girls work needs to be changed". Another relative told us, "The girls don't get travel time; they don't get a specific area" and "The office needs to work better with the girls, they are not trained, don't know anything until the last minute". A further relative told us, "They need to sort the timings and look after their staff better. We have had some lovely girls that have left". We found some relatives had raised issues with the branch management team which had not been resolved or shared with the registered manager or provider. This included examples of poor care and safety. This meant that people and their relatives could identify a number of ways in which the provider should improve that the provider had not identified and addressed.

We found the provider had put in place audits and audit systems in order to monitor and review the quality of care. These were supported by appropriate policies. However, we found these systems were not adequately applied or overseen by the senior management team. This led to the registered manager and the provider not being aware of the severity and/ or nature of some of the issues which were affecting people's experience of the service, such as the widespread issue of missed and late calls. We spoke with the quality and performance manager who told us the new computerised system, which held people's information, staff rotas and other important pieces of information, had been introduced in August 2016. They told us there had been some 'teething' problems with the system which may have allowed some issues we had found to "fall through the net". They assured us the use of the system was now stabilising and they were looking at ways in which it could be further adapted to increase oversight of people's quality of care. However, this meant the provider had failed to apply effective systems in order to assess the quality of service people received. This had led to a poor level of service.

We had been made aware of a number of safeguarding alerts which had been raised with the local authority. We spoke with the registered manager and responsible individual about these matters. They explained that, although matters had been notified to the branch and local authority investigations had been undertaken, these had not always been shared transparently with the provider's senior management team by branch staff. We also found some issues raised by people with the branch management, such as issues about poor care and safety, had not been appropriately shared with the senior management, the CQC and the local authority. Due to this and other matters of concern the provider was undertaking investigations to ensure close oversight of the ongoing day to day management of the service. This meant that recurrent issues, such as missed and late calls, had not always been identified by the provider via the use of effective oversight

processes.

The provider had begun to become aware of issues and had discussed the transparent sharing of information by branch staff with the registered manager during a manager's meeting dated January 2017. The provider also told us they had now implemented a cell tracking system which meant the location of staff could be determined and the system could not be tampered with or falsified. However, appropriate use of oversight processes would have identified these issues earlier and allowed the provider to address them before people's care was severely impacted.

We saw senior carers had completed audits of care and care records within people's homes. However, we found these were not effective in identifying some of the issues we identified during the inspection such as improvements needed in records and call times The registered manager told us people's daily records, such as medicines records and care logs, were collected on a monthly basis for auditing purposes. We looked at records and saw these were not consistently collected on a monthly basis. Some records collected had missing sheets, so it could not be determined from written records whether a visit had been undertaken, or what care had been provided. This meant these records could not be relied upon to determine the quality of care provided to people. This meant the provider's procedures for assessing the quality of care has not been adhered to, resulting in a failure to address issues. The registered manager told us they had recognised the senior carers were not in a position to be able to carry out the thoroughness of checks they would like and were developing a new role of team leader. The new team leaders would be responsible for these checks. They also told us they would implement a consistent system of auditing people's complete care records on a rotating basis, so any future lack of reporting of issues by the branch would not be missed.

These matters constituted a breach of Regulation 17 (1) (2)(a)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, .Good governance.

We received information prior to the inspection from different sources that there was a high turnover of staff due to poor working conditions and low morale. The provider had raised the issue of staff retention with the management team in a communication dated October 2016, although we were made aware of issues about treatment of staff post this date. One staff we spoke with during our inspection told us this was an ongoing problem. We spoke with the registered manager about this. They told us they recognised this issue and were speaking to former staff in order to see if they would return to the service. We found the provider was actively undertaking recruitment of care staff.

Staff we asked gave us a mixed response on their view of the culture of the management team. One staff member told us, while they felt positive about the registered manager, the immediate management of the day to day service was poor and impacted on their experience of working for the provider in a negative way. Another member of staff said, "I love my job, but the office is all over the place". One staff told us, "It's stressful. There's not enough leadership". This reflected the information we had received from people who had worked for the service. This included the pressure to attend additional calls at short notice on an already busy schedules of calls.

Staff told us and records confirmed they were subject to regular one to one meetings with supervisors to discuss their performance. However, some staff told us management did not respond adequately to issues they raised during meetings. This meant issues raised by staff were not always addressed.

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 17 HSCA RA Regulations 2014 Good governance The registered persons had failed to ensure systems or processes were established and operated effectively and that such systems or processes enabled the registered person, in particular, to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons had failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed in order to meet people's care needs safely.