Nightingale Homecare and Community Support Services Ltd

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Inspection report

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Ratings

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

Summary of findings

Overall summary

The inspection visit took place at the agency's domiciliary care office on 13 and 14 January 2015. On the 14 January and 19 January we visited people who used the agency in their own homes.

Nightingale Homecare and Community Support Services Ltd are registered to provide personal care to people, living in their own homes in the community. The support hours varied from one to four calls a day, with some people requiring two members of staff at each call. Calls can be from 15 minutes to however long is needed. The agency's office in based in the middle of Ramsgate town centre and the agency offer support and care to people in Ramsgate, Broadstairs, Margate and the surrounding area. They provide care and support to a wide range of people including, older people and people living with dementia and mental health needs. They also provide support and care for people with learning disabilities, sensory impairment and younger adults.

Concerns had recently been identified by the Care Quality Commission (CQC) about the overall management of the three agencies run by the provider. Since the last inspection of March 2014 the service had expanded rapidly and now offered care and support for about 300 people in the local area. The agency had not managed the rapid increase in the number of people and this had resulted in serious concerns being raised.

At the time of the inspection the agency did not have 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 and associated Regulations about how the service is run.

People gave differing views about the service they received. Some people were happy, some were not. Our own observations and the records did not reflect the positive comments some people had made.

People told us they did not feel safe when some staff were supporting them with their care. There was very limited information and guidance in care plans to inform staff how to care and support people in a way that kept them as safe as possible and keep any risks to a minimum. There was no guidance for staff in care plans about how to move them safely or how to provide people with the individual personalised care and support that they needed. People said that when they had their regular staff that knew them well they received the care and support that they needed, however, when different staff came they 'did not know what they were doing' especially when they were moving them or attending to their personal care.

People said that most staff were caring and treated them with dignity and respect and the staff were kind and polite. However, some people said that staff did not listen to them and did not give the care and support in the way they preferred. People were not always involved in the assessment and the planning of their care. The amount of detail in the care plans was limited and the information recorded in the daily notes was not always reflected in the care plans. People told us that their care plans had not been reviewed and senior staff from the agency had not visited them so any relevant changes to their care were not made. They said that every time new or different staff arrived they had to go through everything with them as there was nothing written down.

Staff said the communication between the staff who delivered the care and the office staff who organised the care was not good. People and staff were supported by an out of hours on call system. Staff told us that this was not always responsive and any queries raised were not sorted out. They did not feel supported by staff in the office. They said that they were not listened to. People said that when they called the office, especially at weekends, no-one answered the phone and if they left a message it was not responded to. They said that often messages did not get passed on. There was not enough staff employed to give people the care and support that they needed at the times they wanted it and in a way that they preferred. There were high levels of missed calls to people and staff were often late to calls.

On the whole staff had made appropriate referrals and worked jointly with health care professionals, such as community nurses, to ensure that people received the

Summary of findings

support they needed. However, there were occasions when staff had not taken the appropriate action to contact health care professionals when people needed support with their health care.

People told us that the staff often did not arrive on time and they sometimes felt rushed when they did arrive. On the whole they said that staff stayed the duration of their call. People also said that they did not receive care from a consistent team of staff. They said they often didn't know who was coming and they were not informed by staff in the office when staff were going to be late.

New staff had induction training which included shadowing experienced staff, until they were competent to work on their own. However other staff who had worked at the service for over a year had not received the up to date training to make sure they had the competencies, skills and knowledge to do their jobs effectively and safely. Some staff had not received up to date training in how to keep people safe. During the inspection we found that staff had not raised safeguarding concerns when they should have done. Most staff demonstrated an understanding of what constituted abuse and how to report any concerns. Staff had not received regular supervisions and support where they could discuss their training and development needs. Staff competencies were not checked to make sure they were competent and safe when caring for people.

Staff were not up to date with current guidance to support people to make decisions and consent to care and support. Staff had not received training on the Mental Capacity Act 2005. The Mental Capacity Act provides the legal framework to assess people's capacity to make certain decisions, at a certain time.

People's medicines were not always handled and managed as safely as they could be. There was no guidance for staff to tell them how to give people their medicines safely and in a way that they preferred and that suited them best. Some medicine records were not clear and were not accurate. There was a lack of detailed guidance for medicine needed on a 'when needed' basis.

People and their representatives told us that they did complain when they had any concerns but felt that they were not always listened to and nothing was done to resolve their concerns. When some complaints had been made the management team had not identified them as complaints and had not taken any action to resolve them.

The systems in place to monitor the safety and quality of the service were not effective and were not improving the service. When shortfalls and concerns had been highlighted no action had been taken to make improvements. Staff were unaware of the values and vision of the service and were not involved in the development of the service.

People were supported with their nutritional needs. People told us that they chose what they wanted to eat. Staff prepared meals or supported people to cook.

A system of recruitment checks was in place to ensure that the staff employed to support people were fit to do so. Staff received appropriate safety checks before working with people to ensure they were suitable.

At the previous inspection on the 5 March 2014 there were no concerns.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected from avoidable harm. Not all risks to people were assessed and guidance was not available to make sure all staff knew what action to take to keep people as safe as possible. Senior managers did not monitor incidents and risks to make sure the care provided was safe and effective.

Staff were able to say what they would do if they thought someone was being abused and knew the correct procedures to follow. However, some incidences that needed to be considered as abuse had not been reported.

There were not sufficient numbers of staff available to make sure people got the care and support they needed when they needed it. Safety checks were carried out before staff started to work at the agency.

People's medicines were not always managed safely.

Is the service effective?

Inadequate

The service was not effective

A training programme had not been developed and implemented for staff. The staff did not have the training they needed to make sure people were receiving effective and safe care and support.

Staff did not have regular one to one meetings with the manager or a senior member of staff to support them in their learning and development.

The staff did not understand their responsibilities under the Mental Capacity Act 2005. People's mental capacity to consent to care or treatment was not assessed and recorded.

There was a lack of consistent and robust support available to people and staff outside of office hours.

Staff supported or prepared meals for people to make sure they had a range of nutritious food and drink.

Is the service caring?

Inadequate

The service was not always caring.

Most people told us the staff were 'great' and said staff treated them with kindness and compassion. However, some people told us they were not happy with some of the staff who visited them.

People's preferences were not always considered and acted on and they were not involved with the assessment and planning of their care.

There was a lack of continuity of staff so they were not familiar with the person they were caring for.

Summary of findings

Is the service responsive?

Inadequate

The service was not responsive.

There were mixed views from people about the reliability of the service. Some people told us that they had missed calls and some staff did not always stay the full duration of the call. Other people said that on the whole the staff spent the allocated time of the call with them and usually arrived on time.

Staff did not always respond to people's health care needs.

People did not have the information in their care plan to give staff the guidance to give the care and support that people needed. Care plans had not been reviewed and updated.

The communication with the office staff was not always responsive to people's needs. The office staff did not respond to their telephone calls or ring them back in a timely way. This also applied to the out of hour's service.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not taken appropriate steps to ensure they had oversight and scrutiny to monitor and support the service.

There was a lack of continuity in the management of the service, which had

impacted on people, staff and the service provided.

Roles and responsibilities within the service were not clear and the staff were unsure who they were accountable to and what they were accountable for.

People were at risk because systems for monitoring the quality of care provided were not effective. Records were not suitably detailed, or accurately maintained.

Nightingale Homecare and Community Support Services 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.

This inspection took place on 13, 14 & 19 January 2015 and was announced. The provider was given 48 hours' notice because the location provided a domiciliary care service. On the 13 and 14 January we went to the agency's office and looked at care plans, staff files audits and other records. On the 14 and 19 January we visited and talked to people in their own homes.

Two inspectors and an expert-by-experience, with a background of older people and domiciliary care, completed the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit we reviewed the information we held about the service, including the Provider Information Return (PIR) which the provider completed before the inspection. The PIR 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 also reviewed information we received since the last inspection, including notifications. A notification is information about important events, which the provider is required to tell us about by law.

During the inspection we visited nine people in their own homes. We spoke with the provider, the managing director, the quality assurance manager, the staff who plan and deliver training, a co-ordinator who organised the work for the staff and one member of staff.

We reviewed people's records and a variety of documents. These included six people's care plans and risk assessments, three staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance surveys.

After the inspection the expert by experience contacted 12 people by telephone. We also contacted four members of staff by telephone to gain their views and feedback on the service.

We received feedback from two professionals who had recent contact with the service.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Inadequate

Is the service safe?

Our findings

People told us that at times they did not feel safe when staff gave them care and support. One person said that the regular staff who came knew how to move them safely using special equipment but said that when different or new staff provided their care, "They don't know what they are doing". They said that they did not feel safe at these times and were scared that they may knock their legs. They said that their legs had been knocked on occasions when staff were transferring them in the hoist resulting in them experiencing pain.

There were ineffective systems in place to identify, assess and manage risks relating to the health, welfare and safety of people. There were some risk assessments but the information they contained did not reduce the risks. One care plan stated; 'Support required – Nutrition- Meals prepared. Fluids to prompt. Encourage to eat. Log what is eaten'. The risk assessment said 'May refuse'. This did not give the staff the guidance and information they needed to make sure the person received the care and support that they needed in the way that was safest for them. There was a lack of risk assessments in care plans relating to moving and transferring people safely, administering their medicines and how to reduce the risks of pressure sores developing. There were no risk assessments carried out in relation to staff delivering the regulated activity of personal care in the community on their own.

People were at risk of receiving inappropriate or unsafe care. This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff recently employed by the agency had completed induction training to support people safely, recognise and report abuse, and knew the actions to take, such as reporting issues to their manager and other agencies like the local authority safeguarding team. Staff who had worked for the agency for a longer period had not received up to date training in protecting people from abuse. At the inspection incidents were identified that should have been reported and recorded as safeguarding incidents but staff had failed to do this.

People were not protected against the risk of abuse. This is a breach of Regulation11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was not enough staff employed to give people the care and support that they needed at the times they wanted and in a way that they preferred. There were high levels of missed calls to people and staff were often late to calls. People said calls were often late and staff were not able to stay for the full time. They said that staff were very rushed. One person told us, "The weekends are very bad and it is difficult to get a response from the main office at this time". One person told us they had been allocated a 30 minute visit but the staff spent about 10 minutes and then left. They said, "The staff are very kind but they are in such a hurry they hardly have time to speak to you. Sometimes they don't make the bed properly or finish the dishes".

Staff told us that they felt rushed and were stressed. They said the staff at the office that organised their work, and the managers, did not listen to them and people were at risk of not receiving the care and support that they needed. Staff said they had been told to call the main office if they needed support. They said at weekends they were usually short staffed, mainly due to sickness. Staff told us when they rang the office sometimes there was no reply. When they asked for help they were told that were no extra staff available to help them.

Relatives told us that there were not enough staff, they said staff were rushed and constant 'new faces' caused distress and confusion to people. Social care professionals told us that they felt that there were not enough staff as there late and missed calls to people. They had received reports from the provider to confirm this. The provider was recruiting more staff and were looking at the deployment of existing staff. Some staff told us that they had their hours of work reduced. They said that they could not understand this. They were aware that visits were being missed and the agency did not have enough staff. They felt that the issue was due to the co-ordinating and deployment of the staff. They said the staff who co-ordinated the work were unable to organise the work and did not know which staff were visiting which people and which staff were not. One service user said, "'A' doesn't know what 'B' is doing".

The provider did not ensure there were enough suitably skilled, qualified and experienced staff deployed to safeguard people. This is a breach of Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider was unable to demonstrate that they were assessing and managing risk to the health, safety and

Inadequate

Is the service safe?

welfare of people and the staff who were there to provide care to people. Accidents and incidents had not all been recorded. Four incidents had been recorded but these were incidents relating to staff. Incidents had been recorded about assaults to staff when they had been delivering care to people. However, the risk assessments in the person's home did not reflect that these events had taken place. No action had been taken by the provider to prevent them happening again.

Forms were used to record when accidents occurred. On the day of the inspection staff could not find any of the accident forms that had been completed even though there had been accidents. There was no analysis of incidents and accidents to show any trends or patterns or the need for risk assessments and no learning from adverse events. People were not protected against the risks of inappropriate or unsafe care because the provider did not have a system in place to identify, assess and monitor risks relating to people's health, safety and welfare. This is a breach of Regulation 10 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People did not receive their medicines in a safe way. There were policies and procedure in place but they were not easily accessible to staff. It was not clear in any of the care plans what level and type of support people needed with their medicines. All of the care plans recorded that 'people needed prompting with their medication'. There was no other information in the care plans to detail what support was needed to meet specific and individual requirements relating to obtaining, administering, handling, recording and disposal of people's medicines. Staff told us that they administered and gave some people full support with their medicines. They said that there was no individual direction or guidance for staff on how to give people their medicines in a way that was safe and suited them best. Staff told us that they sometimes left medicines in pots for people to take at a later time. They said that they then signed the medicines record even though they had not witnessed the person taking the medicines. There was no risk assessment or guidance in place for staff to follow to make sure that this was appropriate or that people were taking their medicines safely. Some people needed medicines on a 'when required' basis, like medicines for pain. There was no guidance or direction for staff on when to give these medicines safely. Staff had received training in medicine administration and but their practice was not checked to make sure they were still competent and safe to give people their medicines.

Some people were prescribed creams. Staff told us that there was no recorded information about where and how people's creams should be applied. When staff applied creams this was not recorded in the medicine record sheets. There was a risk of people not receiving their medicines as prescribed. This is a breach of Regulation 13 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff were recruited safely to make sure they were suitable to work with people who needed care and support. Staff recruitment showed that the relevant safety checks had been completed before staff started work. The manager or senior staff interviewed prospective staff and kept a record of how the person preformed at the interview. Records of interviews showed that the recruitment process was fair and thorough. Staff had job descriptions and contracts so they were aware of their role and responsibilities as well as their terms and conditions of work. Staff were issued with handbooks detailing the agency's policies and procedures.

Inadequate

Is the service effective?

Our findings

There were conflicting views about the skills the staff had to support people. Some people felt that the care staff were sent without being given training for their particular needs. One service user stated, “One staff they sent had no experience and didn’t know what to do. When I tried to explain they didn’t listen”.

Not all staff had the right skills and knowledge to support the people with their care. People and their relatives told us that most of the staff were very good, kind and considerate. Some people told us they had regular staff for most of their visits and the staff had the right skills to meet their individual care needs. They said they had built up trusting relationships with them. They said that these staff knew how they wanted to be cared for and supported. People told us that sometimes they did not know which staff would be coming and they were not confident they would know what to do. One person said, “You have to keep explaining the same things over and over again to staff as they send different ones. But at least I can tell them what to do. I do sometimes think about the other people who wouldn’t be able to explain”.

When staff started to work for the agency they received a formal induction which consisted of a four day programme of training delivered by one of the agency's trainers. This included staff's duties and responsibilities, practical sessions on how to support people with their personal care and what to do if people refused care. There were sessions on pressure area care, catheter care, communication, emergency procedures, safeguarding, whistle blowing and complaints, food hygiene, infection control, fire safety, first aid, medication, the Mental Capacity Act 2005, and dementia awareness. There was a whole day practical session on moving and handling people safely. Staff were given a staff handbook and information leaflets on topics covered during training. Staff told us that they thought the induction training was good but was too much to take in, in four days.

Although new staff had received basic training on different subjects during their induction, the training had not continued and staff who had worked at the agency for longer periods of time had not had the necessary training or updates to develop their skills to undertake their role effectively and safely.

Staff told us that sometimes there were training opportunities but they did not have the protected time to attend. Staffs' training was recorded on a computer system which alerted the agency trainer when their training needed to be refreshed. Refresher training was provided by a one day face to face training session with the agency trainer and all necessary training topics were covered in the one day. Staff said that they felt there was not enough time to cover the topics like fire training, infection control, health and safety and the Mental Capacity Act in any depth. They said the trainers just ‘skimmed’ through it and it was not effective. The agency trainer was in the process of reviewing this to make sure it was over a longer period of time and more in depth. They were also developing a training record so that an additional check could be made to ensure that staff remained up to date with all the training that they required.

There was a lack of specialist training to meet people’s individual needs. The agency trainer was aware that staff had not undertaken specialist training. The agency provided care and support to people with a learning disability, but the training department told us they had not provided training for staff in how to support people to be independent who had a learning disability. They said that specialist training was being developed in supporting people with a learning disability, challenging behaviour, diabetes and epilepsy, but this training was not currently being provided. The provider did not ensure there were enough suitably skilled, qualified and experienced staff deployed to safeguard people. This is a breach of Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010,which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not receive received regular supervision and appraisal from their manager or senior member of staff. They did not have the opportunity to discuss their performance and identify any further training or development they required. The staff told us that they did not feel supported by the staff in the office or the management of the agency. They said that no-one listened to them and sometimes when they needed support and help they were not listened to and their requests were not acted on. People were at risk of receiving inappropriate or unsafe care because the provider did not have suitable arrangements in place to support staff in relation to their responsibilities. This is a breach of Regulation 23 Health

Inadequate

Is the service effective?

and Social Care Act 2008 (Regulated Activities) Regulations 2010,which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The agency, on the whole did monitor people's health and care needs. When people needed a doctor or a district nurse the staff contacted the office staff and this was arranged. However, this did not always happen. When one person needed urgent medical assistance the staff had not taken the appropriate action to deal with the situation. There was a delay in the person receiving the treatment and intervention that they needed which left them at risk of becoming unwell.

Staff were not all sure if they had received training about the Mental Capacity Act. The agency records indicated that they had not. Staff did have an understanding that people had the right to make their own decisions. Care plans did not contain information to explain to staff how to best facilitate people's decision making, such as explaining choices and asking people if it was alright with them to give the care and support that they needed. Senior staff had not completed mental capacity assessments to find out if people had capacity to consent to the care and support the agency were going to give. The provider did not have a system to assess people's capacity to make specific decisions and act, with others, in people's best interests. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010,which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs in relation to support with eating and drinking had been identified when they first started receiving care from the agency. Most people required minimal support with their meals and drinks. People told us that the staff supported them to prepare food and drinks and made sure that they had what they wanted. People told us that the staff always left drinks out for them before they completed their calls. They said that the staff made them sandwiches of their choice and others said they had a hot meal of their choice at lunch time.

Inadequate

Is the service caring?

Our findings

People did not always receive care and support from staff who knew and understood their history, likes, preferences and needs. They were conflicting views from people about the staff. People told us that the majority of the staff who visited them were kind, caring and respectful. They said that they received the care and support they needed and in the way they preferred. People said some staff knew them and their routines well. People had been asked if they preferred a male or female member of staff to support them with their personal care. Some people told us that they were given choices and told us that the staff responded to their wishes. They said: '"Most of them do everything that I want when I want". A relative said: "The staff often do over and above what they are supposed to do". "They always ask what else they can do for us before they go".

When people first started receiving care from the agency they were supposed to have an assessment to identify what care and support they needed. Some people told us that they had been visited by a staff member before their care with the agency started; others told us they had not. Some people told us that they had not been involved in planning their care and were not involved when their care needed to be reviewed and updated. One person told us, "A new care plan just arrived one day; it was exactly the same as the old one. I hadn't been seen by anyone. My needs had changed but this wasn't written in the care plan'. There was no evidence to show that people had been involved and had a say about the care and the support that they wanted.

When different staff came people did not receive the care and support that they needed. People told us that some staff did not listen to what they said and were disrespectful. One person told us that they needed their pillows in a certain position at night so they could sleep. They said that some staff ignored their requests and put the pillows how they, the staff, wanted. They said they had been told to 'stop moaning' and the staff 'knew best'. This demonstrated that staff did not always treat people in a dignified manner. People did tell us that their privacy and dignity was maintained whilst receiving their personal care, such as closing curtains and making sure doors were closed.

People said that some staff did not have the right qualities and attitudes. One person said, "Some staff don't listen to what I say". Another person told us 'One night two carers arrived. They were using the hoist to get me into bed. They had just got me over the bed when one of the staff said that they had to go as they would be late for their next call and they left. The other staff member was left struggling to get me safely into bed. It was very difficult for them and for me".

Staff said the communication and relationship between the staff who delivered the care and the office staff who organised the care was not good. People and staff were supported by an out of hours on call system. People said that when they called the office, especially at weekends, no-one answered the phone and if they left a message it was not responded too. They felt they had no one to turn to, to get things sorted out. They said that when they left messages the message often did not get passed on. They felt that no-one cared.

For some people there was a lack of continuity of staff, so the staff were not familiar with the person they were caring for. Some staff told us that were given different people to see from day to day and felt that this meant there was no consistency of care and they did not get to know people and how they preferred to supported and cared for. This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010,which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

Some people said they received consistent, personalised care and support. They were involved in identifying their needs, choices and preferences and how these are met but others said sometimes staff did not explain things clearly to them or give them time to respond.

People's care and support was not documented in their care plan to make sure staff knew how to deliver personalised care. Staff told us, "We have to use our common sense a lot because care plans are not in place or do not have the information we need to help people in the best way." One staff member said "I have been visiting a client for six months and they still do not have a care plan. I initially had to rely on what the person's relative told me to do. I think I am doing things properly".

Some people needed support to move and transfer around their homes. There was no direction in their care plans on how to safely move and handle people even though they needed this support. One person was chair bound and their legs where swollen and at risk of developing leg ulcers, especially if there was any trauma. They used a mobile hoist and a ceiling hoist that were used for all transfers. There was no instruction for the staff on how to move this person safely using the hoists. The person told us that the regular staff who came knew how to move them safely but said that when different or new staff provided her care, "They don't know what they are doing". A staff member told us, "One person I visit needs support to move from the bed to the chair. There is nothing in their care plan about how to do this. They are very unsteady on their feet and could easily fall. I don't know how they should be moved so I move them like the other staff told me too. I am not sure this is the right way".

Care plans did not identify that some people may need care and support to keep their skin healthy and intact. There was no information in any of the care plans to inform staff on how to deliver care to people whose skin may be at risk of breaking down. There was no information about what signs to look for in case sores were developing and what action they should take, like contacting the doctor or district nurse. There was information in the daily records to indicate that staff were applying creams to people's skin but there was no direction were it should be applied and what cream should be used. When people did have pressure sores the local district nurses were visiting.

The care plans did not contain the information needed to make sure people received care and support that was specific to their individual needs. Care plans said for example, 'Personal Care', 'Give medicines', 'Prepare Food'. There was no more information about what level of personal care people needed. There was no direction on how people needed or preferred to have their personal care delivered. One person said "When they are washing me they don't wring out the flannel and just let all the water drip down on me everywhere. It makes me feel cold and uncomfortable".

Some people had not been assessed by senior staff from the agency before they received care. One member of staff said, "The office rang me and told me to go and visit a person. They said they needed total assistance with their personal care and they had memory problems. That was all the information I got. When I got there, there was no care plan. I found that the person was completely different to the information they had given me. They were able to do a lot for themselves and were trying very hard to maintain her independence. I have been visiting her for a while now. There is still no care plan". Other staff told us that they had been visiting a person for six months. No assessment or care plan had been completed and they had to rely on the person's relative to tell them what to do.

Some people had weaknesses on one side of their body because they had suffered from a 'stroke'; because of this they needed specific support with personal care. There was nothing specific recorded in the care plan about how to give the right support. The care plan had a general comment 'assist with personal care'. Some of the care staff did not know the person and some were new staff, recently employed. They had no guidelines to follow about how to give the specific support that the condition required leading to a risk of the person receiving inappropriate unsafe care.

Staff told us that they were often late for 'calls' to people. They said that the office gave them calls following immediately on from each other they were 'too far apart' so a long distance between people's homes. The staff said they were not given any travel time so this often made them late for calls. People also told us that staff did not have travel time between their calls and this could make them late. People were often anxious and upset as they did not know if staff were going to come.

Inadequate

Is the service responsive?

People's care plans had not been reviewed or updated even when their care and support needs had changed. One person and their relative told us their care plan had not been reviewed for two years. No one from the office had been out to reassess the care being provided. People were not involved in developing and reviewing the care and support that they needed.

The provider had failed to plan people's care to protect them from the risks of receiving care which was inappropriate or unsafe. This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The agency had policies and procedures in place to explain how they would respond and act on any complaints that they received. When people started to use the agency they were given a copy of the complaints procedure that explained to them how to make a compliant . This was not written in a format that everyone who used the agency would be able to read or understand. Information and records about complaints and compliments was kept by the agency. Records showed that the detail of any complaint was recorded together with the action taken to resolve it to the satisfaction of the complainant. There were complaints about missed and late calls and the agency had responded to these in writing and had told people how they were going to address them. People told us when they did complain about missed or late calls things got better for a while but the improvements were not sustained. Some complaints had been made but had not be treated as complaints and so had not been investigated and resolved.

The provider did not have an effective system in place for identifying, receiving, handling and responding to complaints. This is a breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

People and staff told us that the service was not well led and not well organised. There was a lack of leadership and direction for all levels of staff. At the time of the inspection the agency did not have a registered manager in post. A manager had been appointed and they were in the process of registering with the Care Quality Commission. Following the inspection we were informed that the manager will not be registering and the agency was in the process of recruiting a new manager.

There was a culture of mistrust and a lack of openness amongst the staff, which meant some staff had left the agency and others were unhappy. Staff working with people did not trust the office staff. Office staff were wary of the management team. Staff felt their views were not sought and valued. The agency had started meetings to improve the communication and relationships between staff.

Roles and responsibilities within the agency were not clear and the staff were unsure who they were accountable to and what they were accountable for. Staff told us that when they rang the office they just spoke to 'whoever picked up the phone'. They sometimes felt they were not listened to and did not get the support that they needed. They said they did not have any confidence in the office staff to take the appropriate action when they needed support and help. One staff told us that they went to a person who required two staff to support them. The other member of staff did not turn up. When they rang the office they were told they would have to 'get on' with it and to ask the person's relative to help them. Staff were not held to account for their own actions. When calls were late or missed no action was taken by the management to address the issues with the staff member.

People were not protected against the risks of inappropriate or unsafe care as there were no effective systems in place to monitor the quality of the services provided or to identify, assess and manage risks to the health, safety and welfare of people. The agency had recently employed a quality assurance manager who was in the process of developing systems to check the quality of the service the agency provided. At the time of the inspection these systems had not been in place long enough to have had a positive impact and improve the service provided. There was no record of any spot checks being carried out to check on staff's performance or to check the service was appropriate and safe. Staff confirmed that they had not been observed in practice or been the subject of any spot check.

There was a system in place to ask people for their views. Surveys were sent out to people in November 2014 and December 2014, however relatives, staff and health professionals had not been sent surveys and so were not included in the quality monitoring of the agency. Returned surveys showed that some people were not happy with the service and had raised issues. Some of the information received were complaints about the service that people were receiving. One person stated that the staff sometimes didn't turn up and they did not receive the care and support that they needed. Another person said that the staff did not stay the 45 minutes which they had paid for. They said staff only stayed 25-30 minutes. This person had identified themselves but no action had been taken and the provider had not responded to the concerns. The person that had been appointed as the quality assurance manager had entered this information on a spread sheet but had taken no action to address these concerns. They had not escalated the issues so that they could be dealt with quickly. There was no action plan to show what they intended to do to improve and to address the issues raised by people. People were at risk of receiving inappropriate or unsafe care because the provider did not regularly assess and monitor the quality of the service or have regard to any comments made about the service. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010,which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were no audits of records including care plans and medicine records to ensure records were accurate, up to date and reflected people's needs. Care plans and risk assessments completed by the staff were not accurate and did not contain the information to make sure people received the care and support that they needed that kept them as safe as possible. Some records could not be located at the agency's office. The provider did not keep accurate records in respect of people using the service. This is a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had not made suitable arrangements to ensure that service users were safeguarded against the risk of abuse. Regulation 13 (2) (3)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 11 (1) (3)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The registered person had not identified and investigated some complaints and had not responded to them in accordance with their policies and procedures. The complaints procedure was not in a format that would be accessible to all the people using the service. Regulation 16 (1) (2)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered providers must ensure that people are protected against the risk of unsafe and inappropriate care arising from the lack of proper information. Records were not accurate, or not available, records were not up to date or in good order. Regulation 17 (2) (c)
	The registered person did not have suitable arrangements in place to ensure that the persons employed were appropriately trained, supervised and appraised. Regulation 18 (2) (a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe. Regulation 12 (1) (2) (a) (b)

The enforcement action we took:
CQC has issued a formal warning to Nightingale Homecare and Community Support Services Ltd telling them that they must take action by 23 February 2015 to make sure that service users are protected from the risks of unsafe and inappropriate care.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person was not protecting service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of health and safety and quality monitoring systems. Regulation 17 (1) (2) (a)(b)(e).

The enforcement action we took:
CQC has issued a formal warning to Nightingale Homecare and Community Support Services Ltd telling them that they must take action by 23 February 2015 to assess, monitor and improve the quality and safety of the service.
Assess, monitor and mitigate risks to the health safety and welfare of service users and others.
Seek and act on feedback from relevant persons to continually improve the service

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not protected service users against the risks associated with unsafe use and

This section is primarily information for the provider

Enforcement actions

management of medicines by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, safe administration and disposal of medicines used.

Regulation 12 (2) (f) (g)

The enforcement action we took:
CQC has issued a formal warning to Nightingale Homecare and Community Support Services Ltd telling them that they must take action by 23 February 2015 to make sure service users receive their medicines safely and on time.

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity. Regulation 18 (1) (2) (a) (b).

The enforcement action we took:
CQC has issued a formal warning to Nightingale Homecare and Community Support Services Ltd telling them that they must take action by 23 February 2015 to make sure there are sufficient numbers of qualified, skilled and suitably trained staff deployed at the service.