Nestor Primecare Services Limited

Goldsborough - Maldon

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an announced inspection of the service on 5 July and 29 July and we further followed up information until 8 August 2016.

Goldsborough Maldon provides a domiciliary care and reablement service to people in their own homes. The domiciliary care service provided care and support to 151 people and 74 staff supporting them. The reablement service provided care and support to 324 people with 106 staff supporting them and had started operating in May 2016.

A registered manager was registered with CQC to manage the domiciliary care service but was on maternity leave during the time of our inspection. The provider had put in place an acting branch manager to oversee the management of the domiciliary care service and an acting manager for the reablement service. The post of registered manager for the reablement service was in the process of being filled. 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.

The service did not have appropriate systems in place to keep people safe. Risks to people's health and wellbeing were assessed but not managed effectively to keep them safe and there were insufficient numbers of staff available to meet people's needs.

Systems were not in place to ensure people received their medicines safely and in a timely way because missed calls and late or early calls were putting people at risk of not receiving their essential medicines.

A supervision and appraisal process including competency checks for staff in carrying out their role was in place but was not consistent across both services.

People were not receiving support and assistance with their nutritional or hydration needs as staff were not turning up within a specified time or calls were being missed completely. People could not be assured that they would receive their necessary drinks and meals as part of their planned arrangements for care.

The service was not always courteous and respectful to people who used it. People did not know when the service was being provided and by whom and they did not receive the service at a time of their choosing. This did not always show the service was caring.

The service was not responding appropriately to people's needs. People were receiving less than an acceptable level of service as they were being left without essential care and support.

Whilst complaints and concerns were being logged, the management had not acted on the information

about the quality of care people had received or looked at how people's concerns could be used as an opportunity to improve both of the services provided.

Some quality assurance systems were in place but were not being used monitor and evaluate the service effectively to provide a high quality service.

There was no visible leadership in the service or clear vision or values. The management arrangements were in state of disarray as there were significant changes going on with the location. However, the provider had started to make improvements to the service to keep people safe.

Care and support plans were sufficiently detailed and provided an accurate description of people's care and support needs. Staff had most of the right information, skills and knowledge to provide care and support to people.

A recruitment process was in place to protect people and staff had been recruited safely.

Staff told us that they were mostly supported in their role and received encouragement to do their job well.

Staff understood people's needs and provided care and support accordingly. People were treated with compassion and kindness by staff who provided their care.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were at risk of unsafe care as their calls were being missed.

Processes were not in place to listen to and address people's concerns and safety.

There were not enough staff to provide people with safe care.

People were not supported to take their medicines safely.

Staff were recruited safely in line with current guidelines.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not receive the support and training they needed to provide them with the information to carry out their responsibilities effectively.

People's nutritional needs were not met by staff as planned to maintain their independence and wellbeing.

Staff did not always have the knowledge and skills to ensure they had taken into account people's capacity and ability to consent to their care.

People were supported to access healthcare professionals when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

The service did not treat people with respect when calls were missed or were late or early. People were not receiving a person centred service.

Staff treated people with compassion and were kind and caring

in the way they provided care and support.

Staff generally listened to people and acted on their views when providing care.

People were involved in making decisions about their care and the support they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not receive care and support that met their assessed needs at a time when they needed it.

People's choices were not always respected and their preferences were not always taken into account by the service.

There were processes in place to deal with people's concerns or complaints but the information was not used to improve the service.

Is the service well-led?

Requires Improvement

The service was not well led.

There was no visible leadership from the management.

People's views were not used to make improvements to the service.

A quality assurance system was in place but was not utilised effectively to make changes for the benefit of individuals and staff.

Staff demonstrated a commitment and enthusiasm to provide good care.

Goldsborough - Maldon

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 undertook an announced inspection on the 5 July which included another visit on 29 July and we further followed up information until 8 August 2016. The provider was given 36 hours' notice of our two visits because the location provided a domiciliary care service and we needed to be sure that someone would be in.

In May 2016, the Provider had taken on the contract from another provider to run a reablement service. People who used the service and staff had been transferred to its base at Goldsborough Maldon.

At the time of our first inspection visit, we were told by the acting branch manager that the reablement service was not part of Goldsborough Maldon so we did not inspect this service at that time. After communication with the provider, it was established that the service was being provided by Goldsborough Maldon and an inspection of this service was undertaken.

Our first visit to the domiciliary care service included one inspector, a member of the CQC medicines team and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who has used a domiciliary care service. The inspection of the reablement service was completed by one inspector.

Before the inspection we reviewed the information we held about the service including any safeguarding concerns and statutory notifications. Statutory notifications include information about important events which the provider is required to send us by law.

On the days of the inspection we spoke with the acting branch manager, acting manager and an operations officer at their office location. We reviewed 19 people's care records, 13 staff recruitment and training files and looked at quality audit records. After the office inspection, we went to visit three people at their homes

and made phone calls to 46 people who used the service. We also spoke with 15 staff members and two social care professionals.

Inadequate

Is the service safe?

Our findings

Most of the people who used the service said that they were safe with the staff who supported them. People felt safe having staff in their home and in the care and support that they gave. One person said, "They do remember to lock the door and put the key in the key safe." Another said, "They come into the bathroom with me I like them to come in – it makes me feel safe."A third person said, "Oh yes very safe with them, very comfortable."

However, some people we spoke with told us that they felt vulnerable and confused especially in relation to the uncertainty of the staff turning up. One person said, "I feel I am left in limbo." Another person said, "They missed three visits, they did ring and as it was late I told them not to bother. It did make me feel a bit scared." Another person told us, "They were late the other day and then accidentally locked me in my house and I couldn't get out. I was really worried and stayed awake all night." And another said, "I was annoyed one Sunday morning when a male carer came at 6.40am. I was scared because I heard noises outside. I told him it's too early I would see to myself as best I could."

People were not being provided with a service which kept them safe. Calls were being missed by staff or staff were arriving too early or too late resulting in people being placed at risk of not having essential personal care, food and drink and not receiving their medicines in a timely way to keep them safe and well. There were a number of reasons recorded for these missed and late calls. These included sickness of staff, lack of communication and up to date information from the office staff to the care staff, electronic system errors and lack of training.

We saw that for both the domiciliary care and the reablement service safeguarding concerns had been raised for those people who had been placed at risk because of missed and late calls and people not receiving their medicine. These were being investigated by the local authority on behalf of people and their families. Information regarding the safeguarding investigations undertaken by the reablement service was provided to us as requested during the inspection which showed the action being taken. However, despite requests, no information about outstanding safeguarding concerns was available to be given to us regarding the domiciliary care service.

Accidents and incidents were recorded on a Complaints Incidents Accidents Management System (CIAMS) which senior management had access to. This included any harm to the person, missed and late calls and any medicine errors as a result and the effect this had had on the people concerned. From the information analysed from this database for the period April/May to July 2016, we saw that for both services, missed and late calls had reduced month on month. However, there were significant incidents of neglect which could have been avoided if efficient communication and rota arrangements had been in place to ensure staff attended as and when arranged.

This is a breach of Regulation 13(4)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had insufficient staff to keep people safe. The acting branch manager for domiciliary care told us that the service was short of staff. A number of staff had recently left and recruitment was being undertaken but not as quickly as needed. This had resulted in people having missed and late calls and the service having to cancel planned visits in advance as they could not be covered, especially at the weekends.

We had received information from the acting branch manager in June 2016 in response to a request for reasons why calls were being cancelled and that, "Coordinators had said they were struggling in certain areas. We are always recruiting and have new care workers in the pipeline." They told us that supervisors also had to go out on calls on top of their usual duties.

The reablement service had also lost staff in the transfer from one provider to another and was in the process of recruiting and training new staff. The acting manager told us that they were trying their best to get to everyone and to work with the planners to get the system better.

People's views reflected the reality of this situation and what it meant for them. One person said, "I should have an hour for my bath and lunch call but they say they can do it in half an hour. I need them to take their time with me, it makes me anxious." Another said, "They ask to combine my tea and bedtime calls, so now I have to go to bed ridiculously early to fit in with them. "A third person said, sometimes the morning is wasted sitting around waiting for them to arrive, I worry I might hurt myself if I do it myself. This doesn't help my independence." A family member said, "The staff come and check my [relative] is OK but only stay about 5 minutes. My [relative] is on their own and doesn't have much company so this is sad that they can't stay the 20 minutes. It's not a lot to ask for someone who has come out of hospital."

We were told by staff that because of staff shortages the planning and organisation of rotas had caused difficulty in staff getting to their calls. For example, staff worked in geographical areas to provide care for a range of people usually within easy distance of their home to reduce travelling time between calls. However, staff told us that the arrangement of the rotas to cover in the different geographical areas was not planned appropriately as staff were traveling long distances to get to people. One staff member said, "It is not unusual that I have to travel about 13 miles to get to one customer, you would think that they would plan it better to have someone closer." Another said, "The rotas are all over the show, chopped and changed around. It's not our fault that we are getting to people late." A third staff member said, "There is an imbalance in the rota system as sometimes I have 5 calls in the morning at a weekend and then on another weekend I have 9/10 calls that I have to get round to. People are not happy that I am an hour late sometimes."

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

We had received information of concern regarding people not receiving their medicines as and when they were prescribed. Missed and late calls had resulted in people not receiving their medicines in a timely way which put them at risk. One person said, "The carers do give me my medicines when they come, trouble is I am not getting them on time when they keep being late or early. I had a couple of missed calls in the morning so I didn't get my tablets at all on those mornings." Another person said, "I do my medicine myself which is a blessing with the number of missed calls I have. I have [illness] so it is vital that I get my medicine – I can't trust them."

The provider used Medicines Administration Record (MAR) sheets to document medicines administration. We looked at records for eight people in detail who were using the domiciliary care service and another five for the reablement service. We found that on most of the MARs we looked at, staff had not recorded the

person's name, date of birth, allergy status and the dates covered by the record. If the records became detached from the folders they were stored in, it would not be possible to identify who they related to or when they had been completed. People could be at risk of unsafe care and treatment if they received medicine which was not prescribed for them.

We saw that where staff applied creams or ointments these were sometimes recorded on the MAR, but in other cases there were notes in the daily record such as 'applied cream' but no record of what the cream was or how it was used. We checked the care plan for one person and could not find any reference to their creams in there. For those people with no clear records, we could not be sure that staff were applying creams consistently and as prescribed.

Although the provider had a MAR template specifically for use with weekly blister packs where it was not possible to identify individual tablets or capsules, these were not always correctly completed. The form included a place to list the contents of the pack, but although we saw one which had been completed, we saw others which were not filled in which meant the provider did not have a record of the medicines administered.

The domiciliary care service had a system in place to audit medicine management. We saw that a supervisor or co-ordinator audited the MARs when they were returned to the office. One of the points checked was 'Are all other boxes completed?' We saw examples where this had been answered yes even though none of the information had been filled in. This showed an untrue record of medicine administration. The reablement service had not completed any audits of medicines administration to ensure staff were completing these correctly and that people were receiving their medicines in a safe way.

We found that for one person the dose of their medicine was unclear. In the care plan it was recorded as three times a day, the MAR chart stated twice a day, and records showed that it was being given once a day. We asked the manager to investigate and confirm that the person was receiving the current prescribed dose.

This is a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recorded additional information in the daily notes which showed that they were supporting people to take their medicines. For example one person was prescribed an antibiotic which made them feel sick and the staff member went to the pharmacy to ask for advice. They were told to give the tablets with food and they recorded this in the notes so that other staff would be aware.

We saw records to show that the provider discussed medicines with people before they started using the service, and assessed and recorded the level of support needed. Responsibilities were clearly set out. Records showed that staff received regular training to administer medicines including specialist formulations such as eye drops and skin patches.

Staff were able to demonstrate a good knowledge and understanding of their role and responsibilities around safeguarding people and protecting them from harm. They told us that they would call the relevant services should an emergency arise and make contact with their manager or the office to report any concerns should they suspect, see or hear anything that they were worried about. A safeguarding and whistleblowing policy and procedure was in place of which the staff we spoke with were aware.

People's care records included risk assessments and guidance for staff on how these risks could be minimised. Risk assessments were comprehensive in most of the care files for people's using the domiciliary

care service. These included details of medicines taken and if people self-administered, care of people's skin, nutrition, risk of falls and use of mobility equipment. External and internal hazards in the environment were also recorded.

Risk assessments for people using the reablement service were more basic than for those using the domiciliary care service, but they covered the risks to people's health and wellbeing and how they should be managed. We were told by the operations officer that a new system for recording information about people's needs would provide updated information to care staff when anyone's arrangements or circumstances changed.

From looking at the staff training files and in discussion with them about their skills and experience, there was a good mix of new and established staff providing a range of experience and skills to care for people safely. Investigations and disciplinary procedures were followed where unsafe practice was found.

The relevant checks were carried out as to the suitability of applicants before they started work in line with legal requirements. This included obtaining satisfactory references and a Disclosure and Barring Service (DBS) check to ensure that staff were not prohibited from working with people who required care and support. Application forms for new staff had been completed with any gaps in employment accounted for; identification and a photograph confirmed the person's identity. Recruitment processes were in place for the safe employment of staff.

Requires Improvement

Is the service effective?

Our findings

The majority of people we spoke with required assistance with food and drink, snacks and meal preparation either temporarily until they were able to do this for themselves or on a more permanent long term basis.

Missed and late calls to people had resulted in them missing their meals or having them at times not of their choosing but when the staff arrived. One family member said, "[Relative] didn't get their breakfast call and was so hungry as they were not able to use the kitchen yet so my sister went and did [relative's] breakfast, they [staff] then turned up at 10.45am. [Relative] didn't get their lunch or dinner visit either on that day." A person who used the service said, "Having my breakfast at 10.30am is far too late for me when I am up at 6.00am and I never know when they will show up."

One person told us, "Last week I had still not had my breakfast call by 10.30am and as a result no tablets, no drinks or food. It happened two or three times that week." Another person said, "I don't have much appetite and they are not helping by doing my morning call so late and then coming back to do my lunch at 12.30pm. I am told I must build myself up to get better but I often miss meals as they are not when I want them. A third person said, "I have my main meal at lunchtime and they miss me all the time. I am not happy." We could not be assured that the service was effective in meeting the nutritional or hydration needs of people who used the service as part of the arrangements made for the provision of their care.

This is a breach of Regulation 14(1)(b) of the HSCA 2008 (Regulated Activities) Regulations 2014.

We looked at records kept in staff files relating to the domiciliary care and reablement services which confirmed that induction, training, supervision and appraisals were undertaken to varying degrees but were not consistent across both services.

We saw evidence that most staff had completed an induction programme, either the Skills for Care common standards or a four day 'in-house' induction programme which included mandatory subjects including medicines management, safeguarding adults from abuse, first aid, eating and drinking and moving and positioning. They then went on to shadow more experienced staff and got to know people who used the service. Where we did not see any evidence of induction, these were the staff files that had been transferred from the previous service.

A programme of face to face training sessions was in progress from June to September 2016 to ensure all staff were trained in moving and positioning people and medicine administration. Some staff had also had more specialist training in dementia care, stoma care and specialist medicines such as administering ear and eye drops.

The training programme for reablement staff to learn about enabling people to increase their skills and independence was underway. New staff and some existing staff had already received this training and said it was, "Really useful" and "It certainly refreshed my skills and reminded me about what was important in my role of enabling rather than doing for." Other staff told us that they had received letters inviting them to the

training which they welcomed. One staff member said, "It will be good to update my thinking about things so I am on the ball."

Out of all the staff we spoke with only four staff told us that they had received specific guidance and training on their responsibilities of the Mental Capacity Act 2005 (MCA) in the past and what this meant in the ways that they cared for people. We saw confirmation of this in their files for training in 2014. The managers for both services said that training in the MCA 2005 was not included in the training programme. Therefore, without this information and guidance, staff may not have the knowledge to be able to put the principles into practice and recognise when people lacked capacity, were unable to consent to their arrangements or made choices which altered their care arrangements..

Some spots checks were undertaken to monitor and assess the competency of new workers but we only saw evidence of these in two of the staff files we looked at. One staff member said, "The introduction to the work was really good. It was all really useful and prepared me for the job."

A system to support staff who worked for the domiciliary care service was in place. Staff we spoke with had received supervision at least twice a year and we saw in staff files that this had been recorded and agreed between both parties .We saw that this had been a two way process and staff had the opportunity to develop their skills. An annual appraisal system was in place to review staff members work during the year and identify any learning needs for the future.

Some staff told us that they knew who their supervisor was and that they felt very supported and could contact them at any time. One staff member said, "I know who they are and [supervisor] has been very supportive when I have contacted the office. Another said, "Any worries about my customers, I have gone straight to [supervisor]." We were assured that staff knew who to contact and were being supported informally during the transition from one service to another.

The reablement service was in the process of setting up a supervision process. The acting manager told us that a process would be available once the new management structure was in place but staff had access to support from both office staff and their managers.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. People told us that their consent was sought before any care and support was provided. Most staff acted upon people's wishes and decisions about their day to day tasks and meeting their needs.

Staff we spoke with were able to tell us how they involved and supported people in making choices and decisions about the tasks they needed support with but were not so aware of the principles about consent and capacity when people's needs change. For example, when a person continually refuses help with support, it should alert the staff to question why this is happening and whether the person's ability to make their own decisions has changed.

The records for people who used the domiciliary care service included information regarding their capacity

to make particular decisions. They or a representative, where required, had signed their records to show that they had consented to their planned care arrangements. One person said, "They do always ask before they do things – they are very particular about that for example, would you like me to do so and so before your shower?" Another two people said, "Oh Yes, they always ask before they do." and "They always ask me what I want them to do first."

However, records for the reablement service showed that whilst a person's capacity had been noted, it had not been fully explored as to information relating to memory loss for example and what that meant in everyday terms, for example, "Appears to have full capacity."

Some people had not signed their consent to their care arrangements but this did not indicate that they were not consenting when support was offered and provided. People we spoke with were generally pleased with the assessment completed by the service and that they had agreed to it. They were appreciative of the support they had received to enable them to be at home.

The provider had updated their policy about consent and capacity in January 2016. It contained a needs assessment tool (used during assessments for new people) and a quick guide to the five principles of the Mental Capacity Act (MCA) 2005. Staff were not aware that the company's MCA policy was available to them. Without this information and guidance, existing as well as new staff, may not have the knowledge to be able to put the principles into practice and recognise when people lacked capacity, were unable to consent to their arrangements or made choices which altered their care arrangements.

People were involved in understanding their health needs and keeping well with input from the staff. Referrals were made quickly when people's health needs changed. Changes to people's care and support were recorded in their care plans and their daily notes to enable staff and other professionals to meet their needs effectively and timely. However, the transfer over to the new electronic system of staff receiving information on their handsets had meant that staff had not always received updated information about people's needs. For example, one staff member reported that often people tell them about changes to their health or appointments rather than the office and another staff member said, "We turn up and the information we have is wrong."

We saw in care plans where professional input had been required for example where the GP or district nurse visited weekly. People's sensory needs were noted, for example which ear a person wore their hearing aid and if it is was working properly. Most people we spoke with reported that their family or friends took care of their health needs regarding opticians, dentists and chiropody.

Requires Improvement

Is the service caring?

Our findings

There was a mixture of views from people and/or their relatives we spoke with about both the services provided by Goldsborough Maldon. People expressed their feelings about how they felt when staff were running late or when calls and visits were missed altogether. The time staff spent with people was compromised, people were being let down by the services and people's planned care and support was not as they expected it to be.

Some people said that whilst late calls could not be avoided it would be courteous for care staff or staff in the office to call and let them know. People told us, "They seem to always be late, and then they have to rush me which I don't like." Another person said, "I told the lady that I didn't want a man coming to me and they sent one. I rang the office and someone told me that if I didn't have him, then I wouldn't get a call. A third person told us, "I found some carers were prepared to do everything but some were not so willing. They were not all kind."

People told us about the way they were being treated by the service and this was illustrated by the views of two people. "They want to come for my bedtime call at 7.00pm. Yesterday I was still having my tea at ten past seven when they came to put me to bed. It doesn't feel very caring." and "I never know who is coming which I feel is disrespectful to me. There are one or two who are always late. My biggest problem is that they come at 5.00pm to put me to bed. It's too early and I have to take a snack with me to bed as it's a long time till they come and get me up in the morning. I then always worry if they will come."

This is a breach of Regulation 10(1) of the HSCA 2008 (Regulated Activities) Regulations 2014.

Some people were very positive about the caring attitude of the staff and that they were kind, warm, friendly and flexible. One person said, "The carer has been with me for four years so she knows what I like off by heart. She comes on time and is very reliable." Another person said, "Generally, I have six different ones come over the week. They are polite and kind." and another person told us, "They are fantastic lovely girls, always asking is there anything else I can do for you. You get the odd one person, but in the main they are marvellous."

Tasks undertaken were completed with the involvement of people themselves and people were enabled to increase their independence with guidance and encouragement. People and their relatives told us that the staff they had had over a period of time knew and understood them and their family members well. They listened and talked to them appropriately.

Enabling people to remain independent, with choice and control over their lives was evident from what people and staff told us and from what we saw in the files. As the reablement service was time limited, agreements were made between the person and the assessor as to an appropriate time when support could be reduced and stopped.

Most of the written content and tone of the records including the daily notes was written in a sensitive and

person-centred way and showed respect and appreciation for the people who used the service. We saw entries in the daily notes where staff had described people they cared for and supported in a respectful and sensitive way and people's privacy and dignity were maintained in the provision of their care. We saw that staff went out of their way for the people they cared for, for example, "On my way in, I bought [Person] some chips, as they adore them from the chip shop."

Requires Improvement

Is the service responsive?

Our findings

Information about what the service could offer was provided to people when they or a health or social care professional made an initial enquiry or referral. A visit was made by the person responsible for assessments to talk about the service and if they could meet the person's needs. People and their relatives told us that their service had been put in quickly usually after a stay in hospital or ill health.

Accessing the two services had different criteria which meant that the assessment and introduction process was slightly different for the reablement service or longer term domiciliary care. The managers told us that they considered if they could meet the needs of a person before a service was started as, for example, to access the reablement service for a six week period people needed to have physical and mental capacity to achieve independence to remain at home.

People had mixed views about the responsiveness of the service and it meeting their needs. This was due to the amount of missed and late calls and the lack of communication they had experienced with the service. It had been recorded that some of the missed visits were as a result of people being discharged from hospital inappropriately before the care package could be put in. Lack of communication between the service and the hospitals and information being recorded incorrectly on the call system had resulted in people receiving less than an acceptable level of service.

The majority of people were not sure of the time the staff were meant to arrive. The acting manager told us that people using the reablement service had a breakfast call between 8.00am to 10.00am, a lunchtime call between 12.00 and 2.00pm, tea time call between 4.00pm and 6.00pm and bedtime call between 6.00pm and 10.00pm. It depended where people were on the staff rota as to if they received a call at the beginning of the shift or the end. They did however, we were told by the manager, have a system which they called 'Time critical', which meant those people who needed medicines or a meal at a certain time were prioritised as much as possible. Staff also thought that people were not getting a good enough service around times of visits. One staff member said, "It's not good people having to have their breakfast at 10.30am." Another said, "People are sweet, they fit in with our rota, but going to bed so early is not on unless they want to."

Some people told us they had been involved in the planning of their care and the assessment of their needs. However, some people were not able to tell us how they had an input into their care plan or how to change it should they want to, for example to particular call times that were convenient to them. One person said, "They don't listen, it's a waste of time complaining as they can't change the rota to fit in with you, you have to fit in with them." Another person said, "I can't get back to my usual routine and interests as I don't know when they are coming."

Care and support did not take into account people's preferences or wishes and was not available when it was needed. We saw in the daily log for one person that their bed calls varied considerably, for example between 21 and 26 June, the bed call was 6.30pm, then 7.51pm, then 8.31pm, then 7.00pm then 5.50pm. It was noted in the daily log by the staff member that," [Person] not very happy about the late and early visits." For another person, we saw in their daily log that they had received a bed call at 7.33pm on 1 June 2016 and

then 5.40pm on 3 July 2016. The service had been refused by the person as they said it was too early to go to bed and had had to call a family member to assist them later. One person also told us, "They want to combine my tea and bed call so they can put me to bed after tea."

We spoke with the acting manager and operations officer about people having a choice in relation to the gender of the staff who provided support to them. They told us that this was not possible, unless it was for religious or cultural reasons. They said that the rotas were organised so that staff had a number of people on their call list. Whilst we saw that when a male member of staff had turned up and the person had complained and requested a female, this had been respected. However, people were not offered a choice at the time of the assessment. This did not show respect for their personal preferences or to maintain their dignity.

This is a breach of Regulation 9(1)(b)(c) of the HSCA 2008 (Regulated Activities) Regulations 2014

People told us that they had a number to contact if they had any concerns or complaints. Over half the people we spoke with or a relative told us that they had had to make a phone call to the office to find out if the staff member would be arriving as they were late or had not arrived at all. Office staff logged people's verbal and written complaints, the investigation and outcome on the Customer Information and Management System (CIAMS). Some information we saw was clear as to the appropriate response to the person, with an apology for lateness or a bunch of flowers being sent to them.

The acting branch manager told us there were 33 active complaints for the domiciliary care service on the system which related to late and early calls, missed calls and where there had been harm to the person, for example, if they had incurred an injury. These were for the period March 2015 to February 2016. They were unsure of the progress of where the investigations into these complaints had got up to as they were relatively new to the service. We asked to see written responses to people's complaints which could not be located on the day of our inspection. The information we asked to be sent to us was not provided and therefore we were not assured that people were receiving appropriate responses to their complaints.

The operations officer for the reablement service provided us with information relating to complaints and concerns since the provider took over the service in May 2016. There had been 35 complaints and 12 of those were open and being dealt with. Over half these complaints were in May and June 2016 when the service was first being set up.

Whilst complaints and concerns were being logged, the management had not acted on the information about the quality of care people had received or looked at how people's concerns could be used as an opportunity to improve both of the services provided.

This is a breach of Regulation 16(1)(3)(b) of the HSCA 2008 (Regulated Activities) Regulations 2014.

The majority of people were pleased with the care and support they received when the staff arrived to make their calls. People told us, "They do mostly stay the whole time but it's all a bit rushed." "I more of less have the same girls, we get on fine and they help me a lot." "They are definitely very patient with me."

Those people who felt involved in their care arrangements told us that decisions about tasks and dates were made jointly so that the service provided met their needs. The service responded to their needs in an individual way and respected their preferences, likes and dislikes. Their views and opinions were taken into account and listened to.

The care files we looked at relating to the domiciliary care service covered all aspects of a person's individual needs, circumstances and preferences and they were signed by the person or their representative. We saw details of an assessment entitled 'About Me' and asked for the person's view about themselves and their needs, for example, one person said, "I can become confused and agitated." Another said, "Aware of my abilities that enable me to remain safe living in my own home."

Clear information for staff to understand people's needs was provided. Their personal care and support requirements, tasks to be undertaken, how many calls were needed, the arrangements for the management of the person's medicines and risk assessments such as nutrition, skin care and hazards in the internal and external environment. People's mobility and use of equipment, their hearing, sight and communication was recorded so that staff were aware of their sensory needs and risk of falls and how to prevent them.

The care plans for the reablement service were not as comprehensive, as they focussed on tasks to be achieved, were mostly not signed and did not detail fully people's preferences and wishes. However, they provided staff with sufficient information to know what support was to be provided. We were told that staff access people's information via a handset which tells them about the address, key safe and main tasks and important information to know before they get to the visit. Staff told us, "Now we have got used to the system, it works very well." Another said, "I can easily find out about a person, it's quicker than the paperwork."

We saw that people's individual assessments and care plans were reviewed as people's needs changed. For the reablement service, the reviews were more regular as they reviewed people's progress towards independence and agreed timescales for the service to cease. We saw one observation in the file which recorded the person as being, "Slow but safe." We were told that a new system of duplicating the assessment record at the time of the assessment would enable information to be given to staff more quickly in order to meet people's needs.

The care plans and daily notes recorded were held in people's homes which allowed staff to share information with each other and health and social care professionals so that the care and support people received was responsive to their daily requirements. These were generally written in a respectful, person centred style as were the care plans.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection, Goldsborough Maldon was in a state of disarray as there were significant changes going on with the location.

The service provided domiciliary care for people who required long or short term personal care and assistance. This service had a registered manager who was on maternity leave. The management had arranged for another registered manager to oversee the service at Goldsborough Maldon. They had been in post for two months. They were supported by a care coordinator also new to the location and existing office and care staff.

The reablement service had been contracted from Essex County Council at the beginning of May 2016. The service and its staff had been transferred over from another provider. This service did not have a registered manager in place but had a staff member acting as a temporary manager until this role could be filled. An operations officer (who had worked for the domiciliary care service) was supporting the manager, along with a team of planners, assessors and care coordinators who were providing administrative and organisational support. Established staff had continued to work for the new provider along with newly appointed staff. A new staffing structure had been developed and was in the process of being implemented.

Goldsborough Maldon did not have a clear vision or direction and was not demonstrating the values of providing a quality service to people and their families. Whilst both managers understood their responsibilities and were dealing with the difficulties of working with new systems and processes, they were not visibly leading the service.

A system to monitor the quality of the service and ensure it delivered high quality care was not in place. Some audits of quality were being undertaken such as care plan arrangements and daily notes, some spot checks of medicines administration and competence, but this was haphazard and not completed in a planned way.

The approach to looking at quality care in terms of the amount of missed calls, late and early calls and risks to people safety had not been managed or investigated effectively for either the domiciliary care or reablement service. However, there was evidence to support that over half of the missed and late calls relating to the reablement service were in May and June 2016 due to the handover of the new service from the previous provider.

When we requested information about audits and checks for the domiciliary care service, we waited some considerable time on the day of the inspection whilst this was located. Also, safeguarding information from the reablement service took a considerable time to be produced for us and extracted from the CIAMS system. Paper records for people were disorganised and not easy to locate and review but were kept confidential. Whilst there was a robust records and data management system in place, we found that utilising information for managing and monitoring improvements was not being undertaken.

The acting branch manager showed us reports to confirm that they recorded and investigated medicine errors. However we did not see that the learning from these incidents was shared with staff. Neither manager had put in place a process to monitor incidents and audit processes to identify patterns which might need to be addressed through training or changes to practice. For the reablement service, we were told that no checks on the auditing of records or staff competency had been completed.

This is a breach of Regulation 17(1)(2)(a)(e)(f) of the HSCA 2008 (Regulated Activities) Regulations 2014

The service was in the process of working cooperatively with all interested parties to resolve the issues and concerns which had been identified before and during the inspection. We were assured that improvements were being made for people who used the service and the on-going monitoring by a senior management team showed a commitment from the provider to make the service safer.

The last customer satisfaction survey carried out spanned the period from June 2012 to April 2015. The area's most needing improvement were communication about the visit such as times agreed, staff arriving on time and changes to staff without notice.

Around half of the staff we spoke with across both services were dissatisfied with the lack of communication to them from office staff and management about their role, developments in the business, information, rota planning and lack of or wrong information being provided to them about people's care arrangements. However, they were motivated to provide good care and their positive attitude and commitment to their role was evident. Other staff told us that they were supported in their role and there was good communication and support with their current supervisor and other staff.

We reminded both the managers of the need to complete statutory notifications and send to CQC. These were completed and sent to CQC as requested.

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 9 HSCA RA Regulations 2014 Person-centred care This regulation was not being met because the service was not appropriate to people, met their needs or reflected their preferences.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect This regulation was not being met because people were not being treated with dignity and respect.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment This regulation was not being met because the service did not have in place a system for the proper and safe management of medicines.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment This regulation was not being met because service users were not being protected from neglect and improper treatment.

Regulated activity	Regulation

Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs This regulation was not being met because people were not getting their assessed nutritional and hydration needs met.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints This regulation was not being met because complaints received were not being responded to appropriately or used to improve the service.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance This regulation was not being met because the management of the service was not robust and there was not a quality assurance system in place that was being managed effectively.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing This regulation was not being met because the service did not have sufficient numbers of staff to care for people safely.