Tailored Care Limited

Tailored Care Ltd

Inspection report

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Date of inspection visit:
28 June 2017
29 June 2017
04 October 2017

Date of publication:
07 November 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Our inspection took place on 28, 29 June and 04 October 2017 and was announced. We gave the provider notice of our visit because the location provides domiciliary care and we needed to make sure there would be someone in the office at the time of our visit.

We last inspected the service on 25 January 2017. The service was rated as "Inadequate" overall following this inspection and placed in special measures. The provider wrote to us outlining what actions they were going to take to make significant improvements at the service. We carried out this inspection to see if the provider had made the improvements required.

Tailored Care Ltd provides personal care for people in their own homes. At the time of the inspection there were 29 people receiving personal care from the service.

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

We found that people continued to experience late, missed or shortened calls as a result of insufficient staffing numbers. This had a negative impact on the care and treatment they received.

We found that people received support with medicines in order to promote their wellbeing. Any risks to people had been assessed, taking into consideration any conditions which may impact on activities.

The provider had taken appropriate steps to ensure staff were appropriate people to deliver care by the use of employment checks. People experienced communication challenges with staff whose first language was not English.

Staff knew how to reduce the risk to people safe by reporting issues of concern.

Staff did not always receive the supervision and training required to enable them to support people effectively. People were supported with food and drink which promoted their wellbeing.

Staff knew the importance of ensuring people consented to their care and worked within the principles of the Mental Health Act 2005. Staff made appropriate contact and referrals to external healthcare when people required this in order to promote their health.

People and their representatives felt staff were caring people. Some people had found improvement in how the management team communication and approached people, although others told us this aspect still needed improvement.

People were involved in their care decisions and reported that staff respected their dignity, privacy and independence.
People were not always supported by a consistent team of staff who knew their care needs well.

Complaints were not always managed and resolved. People often had no response or unsatisfactory responses to their complaints.

People did not speak positively about the management of the service. People felt the management team did not care and staff did not feel supported.

There was a lack of quality assurance systems in place to monitor the quality of the service. The provider had not identified issues in staffing, call times or complaints management.

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

The overall rating for this service is 'Inadequate' and the service therefore remains in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the providers registration of the service, will be inspection again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe.

People continued to receive late or missed calls.

Some people reported communication challenges with staff whose first language was not English.

People received appropriate support with their medicines.

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

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported by staff who had received sufficient training to enable them to support people.

People were supported with enough of the correct types of food and drink to keep them well.

Staff knew how to support people to make decisions about their care in line with legislation.

Is the service caring?

Requires Improvement

The service was not always caring.

People were supported by staff who were caring but felt management were not always caring towards them.

Staff respected people's dignity and privacy.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care from a consistent staff team.

There was a complaints policy in place which allowed people to

raise issues of concern. People had not had their complaints handled in a satisfactory way.

The provider had sent out a recent survey and we saw most responses were positive. The provider had a system in place for following up on issues raised.

Is the service well-led?

Inadequate

The service was not consistently well-led.

People did not feel the service was well led and staff felt unsupported by the registered manager and provider.

Audit systems were not effective in identifying issues around staffing levels, missed calls and complaints management
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Tailored Care Ltd

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Following a previous overall rating of "inadequate" the provider wrote to us outlining the improvements they planned to make. We carried out a comprehensive inspection to check whether the provider had made improvements to the service.

This inspection took place on 28, 29 June and 04 October 2017 and was announced. The provider was given notice because the location provides a domiciliary care service and we needed to be sure that people would be available to talk with us.

The inspection was carried out by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was the care of older persons.

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

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

Inadequate

Is the service safe?

Our findings

During our last inspection of the service we found safety at the service to be inadequate. People received late, missed and shortened calls which had impacted directly on people's wellbeing. The service was short staffed and people complained of poorly trained staff. Guidance around minimising risks to people was not always followed by staff. At this inspection, we found that improvements had not been made and people still received late, missed and shortened calls that impacted on the care they were given.

We asked people and relatives whether the service was safe. We received a mixed response. Some people told us there had been improvements. We asked if people experienced late or missed calls. One person told us, "Well the timing has improved, but still erratic…probably up to half an hour now, never missed me though". Another person told us, "They are generally on time, maybe can be half an hour late… No they've never missed me". A third person told us, "Well they can be late; depends on the previous call but they always turn up. They usually let me know if they're running too late". Another person told us, "They are mostly on time and call me if they are running late most times. No I've not had a missed call". A further person said, "They are pretty well on time and not missed me". Another person told us they sometimes had to get themselves dressed if staff were late in the mornings.

Following the first two days of inspection, we received a number of concerns that people were not receiving their care on time and were still experiencing late or missed calls. We contacted people again to gather their views and found that people were not receiving their care on time. One person told us, "They [staff] can vary from quarter of an hour up to eight hours late. If you call them, it's always 'they are 20 minutes away' but then it goes on and on". A relative we spoke with said, "The carers are never on time. It can be up to two hours or they don't turn up at all. They don't call to let us know, there is no explanation". This was confirmed by staff we spoke with who informed us that calls were often missed or late. One member of staff told us, "People do get calls missed on purpose" and "missed calls are a regular occurrence".

We looked at the systems in place to ensure that people received care at the time that had been agreed with the provider. We found that a system was implemented that would track staff visits and send an alert to the office team where a visit hadn't been started on time. On this system, we identified a number of visits that had yet to be started that day and were classed as being late. We asked the registered manager how this was managed and were informed that the office team who receive the alert would be making phone calls to identify why the visit had not started and arrange for a staff member to attend to the person as soon as possible. However, we saw on the system that some visits were up to two hours late that morning and the registered manager was unable to provide an explanation as to why staff had not been with people at the correct time.

We found that the frequency of late or missed calls had a negative impact on people. For example, one person informed us that they had to limit the amount they drank during the day as they needed support to use the toilet and were not confident that staff would arrive on time to support them with this. The person explained that they chose not to drink so that they would not need to worry about using the toilet if staff did not arrive when expected. This meant that the person may be at risk of infection or ill health due to not

drinking sufficient amounts of fluids. Missed calls had also resulted in this person being unable to take their prescribed medication as staff had not arrived to support with this. A relative we spoke with told us that their family member was unable to drink after a certain time each day, but as staff were often late to visit, they missed the opportunity to provide the person with a drink. The relative explained that they then ensured that their family member gets their last drink of the day.

We asked people if staff stayed for the full length of the call and whether they completed all aspects of care as agreed. We received a mixed response from people. Some told us staff were not rushed and completed their full care needs, while other people told us staff were often rushed. One person told us, "Yes, they are always in a rush to get off and sometimes won't cream me because of that, but most usually just stay the time, but some don't". Another person told us, "They are in an out, just do what's needed and go. Always in a rush to get to the next call". A further person said, "They always stay [the expected time] and don't rush". One person told us, "Yes they always stay their time even if late". Another person said, "No they don't rush me. I can only stand and can't walk so they have to be patient with me".

Following the concerns raised after the first two days of inspection, we spoke with people again to find out if people had received shortened calls since our first visit. One relative told us, "Some [staff] do stay the correct length of time and some don't".

We checked the records for four people and saw that three of these had received shortened calls in the previous weeks. Some calls had been shortened by up to 25 minutes. We saw one visit that was meant to take 45 minutes, had only been 10 minutes. We could see no records to indicate why staff had not stayed for the agreed length of time. Staff we spoke with told us that calls often had to be cut short as they did not have enough time to visit all of the people they needed to support and so needed to cut calls short in order to visit everyone. One staff member told us, "We can't give them [people] the care they need in the time we are given" and "If we call the office to say we can't fit everyone in, they just say 'if we authorise you to cut the calls short, can you do them then'". We spoke with the registered manager about this who informed us they had not been aware of staff not staying at visits for the required time, but felt this was due to people asking staff to leave early as all their care needs for that visit had been met. However, we could see no evidence to support this.

We spoke with the provider about current staffing levels. We found the service had employed a number of new staff to increase overall staffing numbers. We saw the provider was continuing to recruit staff and had appointed a staff member into a specific role to help with this. However, despite this increase in recruitment, people and staff we spoke with did not feel there were enough staff available to meet their needs. One member of staff told us, "We are covering a wide area as there is no staff" and "We do not get a break, all of our calls are back to back and do include travel time but these are unrealistic. They give you five minutes to make a 20 minute journey". We spoke with the provider and registered manager about how they ensure they have sufficient number of staff. The provider told us that they know they have enough staff as all of the visits are allocated. However, they had not identified staff concerns about being rushed or not having sufficient travel time. We found that there were no systems in place to review staffing levels.

This meant that the provider had not ensured that there were sufficient numbers of staff in order to meet people's care needs.

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

We found the provider took steps to ensure staff were appropriate people to deliver care. We saw that

recently recruited staff were subject to employment checks. These included police checks and references. Staff confirmed they were subject to the completion of employment checks before they were permitted to start work. Some people told us they sometimes found it difficult to communicate with staff whose first language was not English. We discussed this with the provider who told us they assessed potential recruit's communication abilities during face to face interviews. However, this meant that some staff and the people they cared for could not always communicate clearly.

During our last inspection we found people were not always given the support they needed to take prescribed medicines. We asked people if they now received the correct support with medicines.

One person raised a specific issues concerning one staff member in respect of the application of their topical creams. This person also raised other issues of safety. We raised these issues directly with the provider who undertook to address this with the relevant staff member.

All other people and relatives we spoke with told us staff ensured they received correct medicines, which was a significant improvement since our last inspection. One person told us, "Yes, they give me my tablets with some water in the morning, and they look at my papers to see what I have". Another person told us, "Yes they give me my eye drops that I need five times a day and I have soluble tablets…They are very careful when they do my meds. I am confident in them doing all that for me". A third person said, "They get my tablets out of a [pharmacy date organised] box and give them to me as required". A further person explained, "They do my eye drops for me but I do my own tablets. They are very careful and gentle when doing that". A Relative told us, "They cream him and check for any sores and cream them as required as well". Another relative said, "They put ointment on her feet and legs and always ask if they can anything else". This meant people received the medicines they required to keep them well. This was a significant improvement from what we found during our previous inspection.

Risks to people had been assessed. We spoke with staff about how they addressed potential risks to people during the provision of aspects of their care. Staff were able to accurately reflect how they minimised risks to people. This included how to assist people to move safely around their homes. Records we looked at confirmed what staff told us. Risk assessments had been completed in a person centred way which considered how people's sensory abilities or pain might impact on certain activities. For example, one person had a degenerative eye condition and this was considered as part of their falls risk assessment. This meant staff knew how to support people safely, while considering all conditions which could impact on the safety aspects of certain activities.

Staff were clear about their duties to report suspected abuse. They were able to tell us how they could report such matters both internally to management and externally to outside agencies. They demonstrated they were able to identify the signs of abuse. This meant that staff knew what action to take in order to protect people from harm.

Requires Improvement

Is the service effective?

Our findings

During our last inspection we found that staff were not always skilled and knowledgeable about areas of care which affected people. At this most recent inspection, we found that some issues remained around a lack of staff knowledge of people's needs.

We asked people if they felt staff were trained, skilled and able to meet their needs. We received a mixed response. One person told us, "It could be better". Another person told us, "No not really…the training needs to be improved". One relative we spoke with felt that staff did not have the training required to support their family member's specific needs. The relative told us, "They [staff] do not have a clue what they are doing, useless. They are terrible". The relative explained that because of their family member's medical condition, they required staff to encourage them with their personal care. However, this had not been happened. The relative informed us they felt it was due to a lack of understanding of the person's condition.

Other people we spoke with were more positive about staffs' skill levels. One person told us, "Yes the carer's are fine on the whole". Another person said, "Yes I do [think they are skilled]". A relative told us, "[Person's name] is non-weight bearing and so needs to be moved into [their] chair and they are very careful when moving him around. They all appear to know what they're doing".

Staff we spoke with were not consistently positive about the training they received. A new member of staff told us they had completed induction training and a period of shadowing before they were permitted to deliver care independently. They told us this process had allowed them to become familiar with their role and they felt confident in caring for people. We found records of induction which supported this. However, other staff spoken with felt that their induction training did not equip them for the role. One member of staff told us, "The training is only three days, some don't even get that. If we are short, they [new staff] get thrown straight in".

We found staff completed training in areas of care which directly affected the people they supported. For example, this included training in how to assist people to move safely. The provider had employed a system to monitor which staff had completed mandatory training and which staff required update training in order to ensure their knowledge was current. Staff completed the Care Certificate. This is a nationally recognised certificate designed for staff working in the care industry. It showed that staff who had completed it have been assessed in important areas of care. However, some staff reported to not have received any further training following their initial induction. One member of staff said, "There is no ongoing training, only the three days induction".

This meant that while some staff received training relevant to their role, improvements were still required for the provider to ensure that all staff received the training they required, and that people receiving support could be assured that staff have the knowledge required to support them effectively.

During our last inspection we found that some people did not received the food they required at appropriate times. This included people who had diabetes and who needed to ensure they ate at certain times. This put

people's wellbeing at risk. During this inspection people told us staff prepared the required meals when they needed them. One person told us, "Yes, they get my breakfast toast and a cup of tea and a microwave meal for my lunch. They get me my drinks, and for tea a sandwich as well". Another person told us, "They get breakfast and prepare dinner for me in the morning. At lunchtime they give me my dinner and leave me a drink and wash up. At teatime make me a sandwich, that's all I need then. They always see that I have eaten and had a drink". A relative told us, "I get [the person's] meals, but they do get [them] a drink if [they] want one". This meant people received the food and drink they needed to keep them well. We spoke to staff about people's dietary needs. Staff showed knowledge of people's food and drink requirements. We also looked at people's records. These provided staff with guidance on people's nutritional needs.

People we spoke with were able to make decisions about their care, or had appointed a representative to speak on their behalf. Staff demonstrated they knew how to support people in making decisions. Records provided staff with guidance about how to understand people's choices. Staff showed a good working knowledge of the Mental Capacity Act and how this could affect people's care and decisions making. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People and their relatives told us care staff would support people to contact external healthcare professionals if this was needed, although this need had not arisen for them. One person told us, "They certainly would I think". Another person said, "Oh I feel sure they would". A relative told us, "Yes, if something is wrong they will always tell me". We looked at records and saw they provided staff with guidance on when referrals would be needed to be made to external healthcare professionals, such as district nurses if someone's skin became sore. Staff we spoke with confirmed they were aware of which people were vulnerable to certain conditions, such as sore skin, and how and when they should take action to support these people. This meant staff knew how to support people with their healthcare needs as required.

Requires Improvement

Is the service caring?

Our findings

During our last inspection we found that, while staff were caring people, the provider had not provided a service which was consistently caring. People described the management team as sometimes having a negative approach to them when they raised issues about the service.
At this inspection we found that improvements had not been made to ensure that systems were in place for people to receive a caring service.

People and relatives we spoke with were positive about how caring staff were towards them. One person said, "It's ok. They do care. I don't complain". Another person told us, "The care is fine. They are nice girls and very pleasant and caring towards me". A third person explained, "I am very happy and confident with them". Another person said, "Quite happy. They are all nice and friendly". Relatives we spoke with were happy with the caring approach of staff. One relative told us, "Very good. All the carers; whoever comes has a caring attitude". Another relative said, "The carers are very nice and good". However the providers systems and process still had shortfalls that meant people did not always receive a service that was caring. For example, people experienced late and delayed calls, and there was a lack of staff training and knowledge.

People gave us a mixed response when we asked if the approach by the management team had improved. Some people told us things had improved. One relative said, "It's been alright. They have improved". Another relative told us the management were mostly helpful, but their approach could still be improved. One person told us "It seems alright. I get my calls. The office is down the road from me so I can call in to see them and I find them all very nice". Other people told us the management team still needed to improve their way of communicating. One person described them as being "abrupt". Another person told us, "Very poor. Waste of time when you call to complain". This meant that, while there were some improvements in respect of the caring offered by the management team, the way in which they communicated with some people still required improvement.

People told us they were involved in planning their care. One person told us, "They do listen. If I say to them "I need to be cleaned here" they do it". Another person told us, "They do listen and they are respectful to my condition". We found assessments of care had been carried out and people or an appropriate representative were involved in this process. Records supported the fact that people and their relatives had been involved in important decisions affecting their care.

People told us staff respected their dignity and privacy. One person said, "Yes my privacy and dignity is fully respected by them". Another person explained, "They are careful to cover me and close the curtains if I want". A third person told us, "They are very respectful which is why I have a lady to wash me in the morning and not a man". This meant the provider respected people's preference of staff gender. Staff gave us clear examples of how they would support people's privacy and dignity. One staff member told us, "I would check how many people were needed to help the person bathe. I make sure the doors are closed and people are as covered up as they can be". Another member of staff told us how they would make sure care was provided away from other members of the person's household in order to support their privacy.

Staff were clear about their duty to improve and support people's independence. One staff member told us they would check what tasks people wanted to complete for themselves. Another staff member described how a person's ability to carry out certain self-care tasks would vary depending on how they felt that day. They described how they would assess this by speaking with the person and encouraging them to do as much as they were able to. Care plans were written in a way which gave staff guidance on how much support people required and what they preferred to do themselves.

Requires Improvement

Is the service responsive?

Our findings

During our last inspection people and their relatives told us that they did not always receive care from a consistent staff group who were familiar with their needs and preferences. People told us the provider did not always deal with complaints in an appropriate way. Issues which had been identified had not always been addressed.

We asked people if they were supported by a regular group of staff who were aware of their needs and preferences. One person told us, "I keep telling them I would like regular carers but they don't take any notice". We spoke with the branch manager about consistency of staffing. The branch manager demonstrated that they were in the process of continuing recruitment of staff and the reassessment of 'rounds' staff would be completed. This meant that the provider was still going through a process of staff reorganisation which was not yet completed.

However, on the third day of inspection, we spoke with people again to find out if they now received a regular group of staff. People and relatives we spoke with confirmed that they did not have a regular team of care staff. One person told us, "No I don't always have the same staff, they don't have many staff anyway". A relative said, "There is no continuity of care, different carers all the time".

This meant that the provider had failed to ensure that people were supported by a regular team of staff who they were familiar with.

We asked people if the provider dealt with complaints in an appropriate way. We received a mixed response. One person told us, "Yes [I have complained] to the office regarding calls. When you do phone they are abrupt and give the impression they aren't listening and fob you off. Nothing has changed there". Another person said, "I even sent [a complaints] form in but had no response". A relative told us, "You phone them up but they make excuses. You can't believe them".

Other people said that things had improved when they had raised issues. One person told us, "[I've complained] only about the lateness of the calls and wanting a rota. It's got better, but still problematic. I never get a rota". One relative told us, "[I've complained] a lot in the past but like I say it has improved with the calls 'saga'. The only recent complaint was verbal about that one carer's attitude and they promptly replaced her".

We looked at the way I which the provider was addressing people's concerns. We saw that the branch manager had been progressing complaints in line with the provider's policy. This included responding to people in a timely way and liaising with other support agencies, such as the local authority in order to attempt to resolve matters. However, we did not see records in relation to complaints that people told us they had made. This means that complaints had not always been accurately recorded and people's views were not listened too.

We asked people whether the provider routinely sought their views about the service. Some people and

relatives recalled receiving a questionnaire from the provider. One person told us, "Yes, I had a form and sent it back". A relative told us, "Yes they sent out feedback forms and I sent them back". We found that the provider had carried out a recent survey and was contacting people, following our last inspection to understand how they could improve people's experience of care. We saw that many of the surveys completed showed that people were more satisfied with the service than they had been previously. We saw the management team were taking steps towards addressing people's concerns, but this work was still on going.

Care records were written in a person centred way. Records focussed on what people were able to achieve, as well as what support they needed. People or their representatives had routinely signed care records. This showed their knowledge of the content of records and their consent of the records. Care records were regularly updated. This provided staff with the latest guidance on how people wished and needed to be supported. Staff we spoke with were clear about people's current needs.

Inadequate

Is the service well-led?

Our findings

During our last inspection we found that the service was poorly managed. While the provider had put in place systems and audits which should have identified issues people were experiencing, such as late calls, the provider was not adequately overseeing these systems and so was unaware of the extent of issues people were experiencing. This resulted in some people experiencing a poor level of care which impacted on, or risked their wellbeing. We found that the management at the branch were not consistently transparent with the senior management team about issues being raised by people or other concerned agencies. At this inspection, we found that the provider had failed to address these issues and that concerns remained about the provider's oversight of the service. The provider had failed to make the improvements required to improve the quality and safety of care for people .

We found the management at the service had recently changed. A branch manager had been recruited prior to our first visit in June and was present for the first two days of the inspection. However on the third day of inspection, the branch manager had resigned from the position and recruitment was ongoing for a new manager. In the interim period, the registered manager was overseeing the daily management of the service. The service had two different branch managers since the last inspection in January 2017, this meant that there had been a lack of stable leadership at the service since the last inspection.

We asked people and their relatives what they thought about the management of the service. We received a mixed response. Some people told us the management had improved while others still felt improvements were required. One person told us, "Well I personally have no complaints about any of that". Another person told us, "It seems alright". A further person told us, "Well to be fair they handled the lateness of calls alright". A relative told us, "It's been alright. They have improved". Other people were less positive. One relative told us, "Could be better. Well nine times out of then they will try to assist but they do make excuses, so definitely room for improvement".

Following the concerns raised after the first two days of inspection and the departure of the branch manager, we spoke with people again to find out if they felt the service was well led. We found that people were not satisfied with the support they received from the provider or the registered manager. One person told us, "It is like they [management] aren't bothered, they aren't bothered about their customers, it's disgusting". A relative we spoke with said, "It is a waste of time talking to them [the management team] as they are not bothered".

During our last inspection staff raised concerns about low morale at the service and criticised the management approach. Staff told us they had been positive about changes the branch manager had made. One staff member told us, "I'm not just saying this, there have been a lot of changes for the better. I just love it now. The management was bad before, but that's all changed now." However, as the branch manager had left the service before our third day of inspection, we spoke with staff again to find out how they were being supported with the new management structure. Staff we spoke with did not feel supported by the registered manager and provider. One member of staff told us, "There is no support at all". When asked about supervisions with the registered manager, the member of staff said, "No supervisions have been done since I

started, there's no point anyway as she [registered manager] doesn't listen".

We found the provider had systems in place to monitor and address matters of quality, however these were not being used to consistently to identify and action areas for improvement. We saw that visits to people were being monitored by dedicated staff who worked centrally for the provider. This included two members of staff who monitored a system which showed where staff were at any one time. Reports on staff locations and whether staff had arrived at calls on time was emailed to the branch manager so they could assess where issues might be occurring. However, the registered manager had not used these reports in order to identify where calls had been late, missed or shortened and so no action had been taken to reduce the risk of these reoccurring in the future. We spoke with the registered manager about this who informed us that auditing processes for late or missed calls were not in place as they were dealt with daily where the issues occurred. This meant that the provider and registered managers had no clear oversight of the scale of missed, late or shortened calls as they had not implemented systems to monitor these.

The registered manager and provider were not able to evidence that they audited records such as medication administration records to ensure care was being given in a safe way. The registered manager informed us that a sample of records were audited each month to identify any issues but were unable to show us records to evidence these took place. This meant the provider was unable to ensure that people were receiving the appropriate care and support as there were no systems in place to review the records completed during visits.

People we spoke with told us they were not confident that their concerns were listened too or acted upon by the registered manager. One person said, "They write it all down but never do anything with it". A relative told us, "I have complained directly to them [the registered manager]. It's a waste of time as nothing changes". We found that while some complaints were recorded and we could see action had been taken, there were some complaints that had not been resolved to the satisfaction of the person. There were no systems in place to audit complaints made to identify trends or patterns with a view to making improvements to the service.

Despite people making complaints about staff being late to calls or not staying the agreed length of time and staff identifying that they do not have time to support people appropriately, the provider had failed to act on this feedback and review the staffing levels to ensure that a suitable number of staff were available to meet people's care needs. This had meant that people continued to receive care that did not meet their needs as there were insufficient numbers of staff available.

The provider lacked oversight on the issues identified during the inspection in relation to staffing levels, a number of missed, late and shortened calls and had no quality monitoring systems in place to ensure that these concerns were identified and acted upon.

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

The provider had a legal duty to publicise their inspection rating on the provider's website. We checked the provider's website and found the provider had carried out these legal duties. We saw that notifications had been sent in to us as required by law.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure that systems were in place to monitor the quality of the service being provided and lacked oversight on issues including the missed, late and shortened calls being experienced by people.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staff were sufficiently deployed in order for them to provide people's support on time.