

MiHomecare Limited

MiHomecare - Wiltshire

Inspection report

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Ratings

Overall rating for this service

Inadequate ●

Is the service safe?

Inadequate ●

Is the service effective?

Inadequate ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Inadequate ●

Is the service well-led?

Inadequate ●

Summary of findings

Overall summary

We carried out this inspection on 14, 22 and 28 April 2016. This was an announced inspection, which meant the provider knew two days before we would be visiting. This was because the location provides a domiciliary care service. We wanted to make sure the manager would be available to support our inspection, or someone who could act on their behalf.

MiHomecare Wiltshire is a large domiciliary care agency, which provides care and support to people in their own homes on a short and long term basis. The agency manages the local authority's Help to Live at Home contract.

At the last comprehensive inspection, which took place on 16, 26 January and 6 February 2015, we identified the service was not meeting a number of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care was not delivered in a way which met people's needs and missed visits were occurring. There were also insufficient staff to meet people's needs, medicines were not being safely managed and staff had not received adequate training to do their job effectively. In addition, the agency's auditing systems were not identifying and addressing shortfalls in the service. After the inspection, the provider wrote to us to say what they would do to meet these legal requirements.

We carried out another inspection of the service in September 2015. This was to ensure the provider had been following their action plan and making the improvements required. Progress had been made, especially in terms of the reliability of the service. However, at this inspection improvements had not been sustained and there were widespread shortfalls in the majority of the areas looked at.

The agency had 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. The registered manager was present throughout the inspection.

There were not enough staff to ensure people received their planned visits. Due to this, a proportion of all visits were regularly given to another care agency to complete. This did not ensure consistency. In addition, the staff team were working at full capacity. This meant if a member of staff called in sick at short notice, there was little flexibility with arranging cover. Staff shortages and errors in communication had caused some missed visits. Staff had not always ensured follow up action had been taken, when staff could not gain access to a property. These shortfalls placed people at risk of significant harm.

People's medicines were not managed safely. Records did not show clear instructions of the medicines prescribed and not all information was up to date. Staff had not signed the administration records appropriately and had not received up to date training in medicine administration. Staff's competency to administer medicines and specialised training to administer prescriptions such as eye drops had not been

undertaken.

Not all staff had received up to date training to do their job effectively. Staff were not regularly meeting with their manager to discuss their work and any concerns they might have. Spot checks to monitor staff's practice were not taking place, in accordance with the agency's policy. There was little evidence that staff received support when requested.

People's care was not regularly reviewed and specific issues such as resistance to care had not been identified and addressed. The scheduling of people's visits was not always conducive to people's needs. There was some concern about the consistent timings of visits. However, those people who received regular staff to support them were very complimentary about the service they received. There were positive comments about the qualities of staff and their willingness to assist, where they could. People told us staff promoted their privacy and dignity although the shortage of staff sometimes impacted on this.

Systems in place to enable the management of the service were not always effective. Checklists or schedules did not show when certain practices such as staff supervision should take place. There were no systems to ensure staff had valid identity badges or their documents for car safety were up to date. Shortfalls in the service were not being identified and appropriately addressed. People had been asked for their views about the service by an annual telephone survey. However, more regular contact to monitor on-going quality had not been undertaken.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

This service was not safe.

There were not enough staff to cover all care packages and to meet people's needs effectively.

There had been some missed calls and action was not always taken when staff could not gain access to a person's property. This placed people at risk of significant harm.

Medicines were not safely managed.

Is the service effective?

Inadequate ●

This service was not effective.

Not all staff had undertaken training to equip them to do their job effectively.

Systems to support and supervise staff were not being undertaken in accordance with the agency's policy.

Whilst people were positive about the regular staff who supported them, inconsistency of visits, particularly at weekends caused some concern.

Is the service caring?

Requires Improvement ●

This service was not always caring.

The inconsistency of staff supporting people, did not always promote their privacy and dignity.

People were complimentary about the staff with comments made about their approach, attitude and willingness.

Staff were aware of the importance of promoting people's rights.

Is the service responsive?

Inadequate ●

This service was not responsive.

The planning and allocation of visits did not always meet people's needs.

Care documentation lacked detail and did not consistently inform staff of the support each person required. People's support was not regularly reviewed and key issues, were not always identified and addressed appropriately.

People and their relatives knew how to make a complaint. Complaints were taken seriously and properly investigated.

Is the service well-led?

This service was not well led.

There was a registered manager in post. They were aware that insufficient staffing was impacting on the service provided.

Systems did not enable efficient monitoring of the service. Shortfalls were not being identified and addressed appropriately.

Due to priority being given to the allocation and completion of people's visits, gaining on-going feedback about the service, had not been undertaken.

Inadequate ●

MiHomecare - Wiltshire

Detailed findings

Background to this inspection

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

This inspection was announced and took place on 14, 22 and 28 April 2016. The inspection was undertaken 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.

We spoke with 15 people who used the service, three relatives and six members of staff including the registered manager. We looked at people's paper and electronic records and documentation in relation to the management of the agency. This included staff supervision, training and recruitment records, quality auditing processes and policies and procedures.

Before our inspection, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification.

Is the service safe?

Our findings

At the last comprehensive inspection, which took place in January and February 2015, we identified the service was not meeting Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were insufficient staff to meet people's needs and visits were inconsistent with some missed calls. In addition, the inconsistency of visits meant staff were not always aware of people's needs. This compromised the support they received. After the inspection, the provider sent us a written plan, which stated the actions that would be taken, to ensure improvement. We undertook another inspection in September 2015 to make sure the action plan was being followed. Immediate action had been taken to address the shortfalls. However, at this inspection, the improvements had not been sustained and concerns about inadequate staffing remained.

The registered manager told us there was a strong recruitment drive to appoint new staff to the team. However, there were still not enough staff to undertake people's visits effectively. A proportion of people's visits were regularly given to another care agency to undertake. This did not ensure continuity or enable staff to have a clear awareness of people's needs. The staff team were working at full capacity. This meant it was a challenge for staff to undertake any extra visits, to cover staff sickness at short notice. There had been occasions when people had not received their visit and had not received the support they needed. One person had assisted themselves on to the commode at 7pm, so they would be ready for when staff came to support them an hour later. However, this call was missed and the person finally received support at 10pm. Whilst the person was not physically harmed, they were emotionally distressed. Missed visits were particularly apparent at the end of March 2016, as staff had been taking their annual leave and other staff had called in sick, at the same time. This had resulted in there not being enough staff to undertake all visits, which were scheduled. The registered manager told us relatives had been contacted to see if they could provide the support required. However, there had been other visits, which had been missed due to staff error or miscommunication. This included three missed visits between 18 and 24 April 2016.

When talking to people and their relatives about the service, there were concerns about staff shortages and the impact of this. One relative told us their family member had experienced a missed call. They told us "when this happened, I phoned the agency, but trying to get an answer was difficult. They had no alternative they could offer. I ended up having to look after X myself. It really isn't acceptable, but the agency seems to have no answer for the problem of shortage of carers". Another person told us "it does seem to have got better over the last couple of months. However, only last week, nobody came in the morning to help get me organised. I did phone the agency but they said it would be well into the afternoon before they could get me someone, so I took my time, and managed to sort myself out without falling over thankfully".

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

Appropriate action was not always taken if staff were not able to gain access to a person's home. Staff told us they were required to notify the office and a family member or return to the property later, to ensure all was well with the person. However, records did not show this procedure was always followed. Assumptions

such as the person being out, had been made without clarification to confirm this was the case. This placed people at risk of harm, as instead of being out, the person could have fallen or have been seriously ill. Records showed one such incident had occurred. Information about the person's wellbeing had been raised but this was not followed up appropriately. As a result, the person did not receive medical intervention in a timely manner. Whilst this incident was investigated, not all staff involved were interviewed. Information did not show the required procedure had been discussed with all staff. There was no evidence of lessons learnt. "On call" records continued to show occasions, when follow up action was not taken when staff could not access a property. Following the inspection, one person experienced a missed evening and morning visit. This was reported to the local authority's safeguarding team and is currently being investigated.

Assessments which highlighted potential risks to people and staff were in place. The assessments addressed areas such as moving people safely and any concerns within each person's home environment. However, the assessments had not been regularly reviewed. This did not ensure potential risks were being properly identified and addressed. One member of staff had experienced an electric shock whilst using a person's domestic appliance. Records did not show this had been followed up, which increased the risk of it happening again. The registered manager told us they had gained further information about the incident but an outcome had not as yet been agreed.

There had been a number of concerns about people's support, which had been reported to the local safeguarding team. Records of the safeguarding meetings were in place and there were copies of any correspondence. The agency had appropriately assisted the safeguarding team with their investigations. However, the records were difficult to follow. The action taken in relation to the agreed outcomes was not clear. This did not enable a clear audit of the concerns to be undertaken to assess common themes. In addition, the organisation of the information did not enable lessons learnt, to be shared with the staff team, to minimise further occurrences.

The training matrix showed 18 out of 87 staff had not completed refresher training in keeping people safe. The information showed this training was "not applicable" for nine staff, although the reasons for this were not stated. Staff told us they would call the office if they had concerns about a person's safety. However, the completion of training did not comply with the agency's policy, which stated safeguarding training should be undertaken annually.

This was a breach of Regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last comprehensive inspection, which took place in January and February 2015, we identified the service was not meeting Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's medicines were not being safely managed. Full details of medicines were not clearly stated and staff had not appropriately signed the medicine administration records, to show people had taken or declined their medicines. In addition, staff had not received up to date training in medicine management and their competency had not been assessed. After the inspection, the provider sent us a written plan, which stated the actions that would be taken, to ensure improvement. We undertook another inspection in September 2015 to make sure the action plan was being followed. Some action had been taken to address shortfalls. However, at this inspection, the improvements had not been sustained and concerns about the safe administration of medicines remained.

People's medicines were not safely managed. Medicine administration records were disorganised and did not demonstrate a month by month account of the medicines people had taken. Those records, which were in place, did not state the medicines, which were prescribed or their frequency. Staff had not consistently

signed the medicine administration records to show people had taken or declined their medicines. This had been identified during a spot check of a staff member's practice. A further spot check showed discussion had taken place regarding the importance of signing the medicine administration record. However, no additional training had been undertaken. Assessments, which identified potential risks associated with medicines, had not been consistently completed or reviewed. Information did not clearly show what support people needed with their medicines.

Not all staff had undertaken up to date training in the safe management of medicines. Records showed four of these staff, were regularly supporting people with their medicines. The agency's policy stated this training should be completed annually. This had not been adhered to. Staff had not received assessments to ensure their competency in managing medicines safely. This, in addition to limited training, increased the risk of error. Within daily records, it was recorded staff had administered eye drops and topical creams. Specific details of these prescriptions were not stated. Within the agency's policy, it stated specific training was required before staff administered topical creams and eye or ear drops. There was no evidence this training had been completed. Before the inspection, we received three complaints about people not receiving their medicines, as prescribed. Records showed one member of staff had telephoned the office, as they had identified a person's medicines from the previous day, were still in the dosette box. This indicated the medicines had not been taken although a member of staff had signed the medicine administration record, to confirm they had been given. This showed the member of staff had not followed the agency's procedures, which led to the error.

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

Records did not show a robust process was consistently followed in terms of the recruitment of staff. This was identified during monitoring visits undertaken by a senior manager in 2015 but had not been addressed. As part of the process, one applicant had given details of three people who were happy to provide details of their work performance and character. However, not all of these were fully appropriate. One person was a family member, who would not have given an objective account of the applicant. Another was a colleague who had left the company before the applicant, so would not have been able to provide up to date details. The third referee was the applicant's present employer. Whilst this was appropriate, a reference from them was not available in the applicant's file. Reasons for this were given but not expanded upon. Documentation did not show this had been considered in the decision to appoint the applicant, to ensure they were suitable to carry out the work. Records showed the applicant needed to score four or more points in their interview, to be successful. The applicant scored three but was offered the post. There was no information to show the rationale for this decision. The records to show the recruitment process of two other staff were satisfactory although there were no details of the applicant's interview in one.

Is the service effective?

Our findings

At the last comprehensive inspection, which took place in January and February 2015, we identified the service was not meeting Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not received up to date training to do their job effectively. In addition, staff had not consistently received formal supervision to monitor and discuss their performance. After the inspection, the provider sent us a written plan, which stated the actions that would be taken, to ensure improvement. We undertook another inspection in September 2015 to make sure the action plan was being followed. Immediate action had been taken to address shortfalls. However, at this inspection, the improvements had not been sustained.

Not all staff had received up dated training, to equip them to do their job effectively. The agency's policy stated staff were to receive annual training in topics such as safeguarding, first aid, moving people safely, food hygiene and infection control. Records did not demonstrate the policy had been adhered to. The training matrix showed out of 78 staff who were required to complete refresher training in moving people safely, 18 had not undertaken it. 12 staff had not undertaken food safety training and 16 staff had not undertaken up to date training in health and safety. Staff told us they had completed this training in the past but not more recently. One member of staff told us their most recent training course had been fire safety. Another member of staff told us they had done a lot of training but they could not remember what the subjects were. The registered manager told us they had given recent focus to staff training and had prompted staff to complete their "e-learning". In response to this, they said the most recent figures which showed the overall training staff had completed, had improved.

Some staff had undertaken training regarding a person's specific health care needs. This included the use of a breathing machine, which was facilitated by the community matron. However, other specific training had not been arranged. This included the use of equipment, catheter and stoma care. One member of staff had asked for this training but there was no evidence to show it had taken place. The training matrix showed some training such as dementia awareness, speaking and listening and caring for your customers was not applicable to a high proportion of staff. The rationale of this was not clear, as the topics appeared integral to the whole team. Those staff who had completed dementia awareness training, had details of the course's content in their personnel file. The information was brief and did not enable an in depth knowledge of the condition. The quality of the training and its impact on staff practice had not been considered.

The system to support staff in their role was not effective. Not all staff had received formal meetings with their line manager to discuss their work. Some sessions had been arranged but not always at the required frequency, as recommended by the provider. The meetings did not show staff were being supported to identify their training needs or to enhance their professional development. Any action plans were not specific in their content. One record showed a member of staff did not want to support a person due to their behaviour. There was no follow up action to support the staff member or any correspondence to show this had been discussed with the person concerned. Other records identified the member of staff required support in other areas of their work. There was no evidence of this being given. There were no documents in place to show the member of staff had received formal support meetings with their manager.

Some spot checks had been undertaken as part of the staff supervision process. However, these were not being undertaken at the required frequency and not all were robust. For example, one record stated the monitoring of privacy and dignity was "not applicable". It was not clear, why this was so, as such rights would be integral to all interactions. Another record showed various shortfalls in the staff member's practice. It was concluded two weekly meetings were to take place, to monitor and further support the member of staff. The meetings were not consistently undertaken and no further training was offered to the staff member. When the member of staff had started work at the agency, they had completed five shadow shifts with more experienced staff. This complied with the agency's policy. However, records to show the staff member's competence had not been "signed off". The agency's policy stated this had to be completed and returned to the staff member's line manager before they could work independently. There was no evidence in personnel files to show an appraisal of each staff member's work had been undertaken. Information stated this practice should occur on an annual basis. The registered manager told us this was partly due to staff shortages and the priority of ensuring people's visits took place.

This was a repeated breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they tried to allocate visits on a consistent basis to enable relationships to be established. They said this was possible for some people, but not for all. Due to staff shortages, some visits were allocated to staff who had space in their "round". This meant there were occasions when staff supported people they knew little about or had not met before. One member of staff told us they did not mind covering shifts at short notice. However, they said excess travel could impact on their ability to support people on time. The electronic scheduling system showed some people had regular staff or a team of staff to support them. Other people did not have this consistency.

People told us the lack of consistency with staff supporting them generally occurred at weekends. One person told us "at weekends, when [my regular carer] doesn't work, it could be anyone, from anywhere, at any time". Another person told us "weekends and holidays can be more difficult because I never know who is going to come through the door. Very often of late it will be staff from a different agency, who I have never met before. I find it's down to me to really explain what it is I need help with. It's really not very good". Another person told us "I certainly told the agency that if they couldn't guarantee I'd see the same usual carers, I was going to be looking for a different agency because I'm fed up seeing different carers all the time, who I've never even met before". Another person told us "apart from weekends or when my carer is on holiday or suddenly taken sick, I see only the two carers. I prefer it this way. However unfortunately, weekends particularly, can be really difficult because I never know who I'm going to get, or when, or what uniform they may be wearing when they come in the door. It's usually somebody I've never met before and it can be really tiring having to explain over and over what it is, you need help with". Staff confirmed inconsistency of visits was greater at weekends. They said this was because the majority of the staff team worked every other weekend so there were less staff available. Staff and the registered manager told us it was anticipated with additional recruitment, this situation would improve.

People were complimentary of staff who supported them regularly. One person told us "when my regular carer is here, she knows exactly what I need help with so I never have to explain anything to her, which is lovely. She's never done anything that I didn't like". Another person told us "I cannot fault my regular carers. I think because they have looked after me for a while, they probably know and understand me better, than members of my family do". Other comments were "the one good thing is that I see the same regular carers. I would be lost without them. They know me and know how I like to be looked after. It's really a pleasure to see them each day".

Records showed some people received support from staff to prepare their meals. Staff told us they offered people a choice of what they wanted to eat. Some people had prepared meals, which were heated in the microwave. Other people chose to have freshly prepared food or snacks such as bacon and eggs. People did not raise any concerns about the meals staff prepared.

Is the service caring?

Our findings

People told us staff promoted their privacy and dignity. A relative also confirmed this. They told us "I'm always impressed by the way the carers make sure that her bottom half is dressed before they put the sling under her and then they always make sure her top half is covered so she doesn't have the indignity of being hoisted, when she is not covered up. I've never had to ask them to do this, they just do it automatically". However, the inconsistency of staff sometimes impacted on people's privacy and dignity. One person told us "I'm an old lady now, and whilst I don't mind getting undressed in front of my normal carer, it can be really unnerving to do so, in front of a stranger. It would be really nice if when I had to have somebody new, they could come with my regular carer, to at least meet me and see what needed doing before they were with me on my own".

Staff told us promoting people's rights was important to them. They said they tried to offer as much choice as possible and always asked people, what they wanted them to do. Staff told us they promoted people's independence and enabled people to do as much as possible, for themselves. One member of staff told us they always ensured people were supported in private and talked to them, to put them at ease. The member of staff told us this was much easier when they visited people regularly, as they could talk about family and importance aspects of the person's life. They said they liked the balance of supporting people they knew but also enjoyed meeting those they had not supported before. They said they felt this "kept them fresh".

People and their relatives were complimentary about the staff. This was particularly apparent when staff regularly supported the same people. One person told us "my carers are really like best friends now, because we have known each other for so long. She never minds bringing in a pint of milk or a loaf of bread if I ask her to". Another person told us "she never minds doing any extra jobs for me and always tells me that her next job will wait a few minutes, if there is anything important, that I need doing." Another person told us "everywhere always looks lovely and tidy and clean when my regular carer has been to see me. She makes the bed, sorts all the rubbish and makes sure that everything is put away before she goes to her next client. Unfortunately, when I have different carers, I can't always guarantee that everywhere will be as tidy. They never leave it in a real mess, but it's just not the same". Other comments were "my regular carers are good", "my normal carer knows exactly what it is I need doing" and "I like my regular carers and as far as I'm concerned, they can't do any wrong. I would be lost without them". Further comments were "my carers know exactly how to look after me and are very caring in their attitude" and "my carer never rushes me, and will always make sure she's got time to tidy the bedroom and the bathroom and make me a cup of tea before she goes each morning".

Is the service responsive?

Our findings

At the last comprehensive inspection, which took place in January and February 2015, we identified the service was not meeting Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the planning and allocation of visits did not consistently meet people's needs. In addition, missed visits were not being identified and care plans did not reflect the support required. After the inspection, the provider sent us a written plan, which stated the actions that would be taken, to ensure improvement. We undertook another inspection in September 2015 to make sure the action plan was being followed. Immediate action had been taken to address shortfalls. However, at this inspection, the improvements had not been sustained.

A spot check of a member of staff, identified one person did not have a plan of their care in their home. Information did not state what was done to address this. Staff told us other people, had a care plan, which they read before providing support. They said this was particularly important, if they did not know the person well. One member of staff confirmed the care plans stored in the office, were a duplicate copy of the information people kept in their home. The office copies were disorganised and lacked detail. The information did not clearly state the person's needs or the support they required. For example, in relation to nutrition, one care plan stated "eating" without any further detail. Another care plan stated the person was prone to depression. Information did not inform staff what triggered this condition, how it was portrayed or what action they needed to take. Another care plan stated staff were to be aware of the person's expected deterioration in health. There was no information about what this involved, how it would be noted or what action they needed to take.

People's care was not being consistently reviewed. For example, one person was at risk of self-neglect and they needed prompting and encouragement to maintain their personal hygiene. Within their daily records, there were almost daily entries of the person's refusal to have a bath or a shower. This had not been identified. The person's care plan had not been updated to reflect the person's repeated resistance and how this should be managed. Within another person's care plan, it was identified they needed to have regular food to assist with a medical condition. Their daily records showed they regularly declined food and told staff to "throw it away". The impact of this had not been identified and considered. The person's care plan did not identify this issue, which was of detriment to the person's health.

People told us if a review of their care had taken place, it was likely a supervisor had done it whilst they were covering a shift of an absent care worker. One person told us "a supervisor had been to me and was covering someone's shift, whilst they were on holiday. They made a point of asking me whether there was anything, which needed updating in my care plan while they were here". Another person told us "I've been with the agency for over a year now but I don't remember ever having a review. I think a supervisor once asked me, if there were any changes that needed making when she was here looking after me one day, when my carer was on holiday".

The agency was not always responsive to people's individual needs. This was because visits were not always convenient for people. One relative told us "we are really night people, so I usually settle mum down

sometimes not until nearly midnight. We explained to the agency therefore mum doesn't really want to be getting up until about 10 in the morning. They will sometimes come at 10, which is great, but you can't guarantee it. For instance, last week, there was a ring on the door at 8:15 and they were expecting my mum to be ready to get up. I explained that it really wasn't on, and that there was no point in staying at that time in the morning. Thankfully they were able to rearrange the visit and came back at 10am, but as they were able to do that, I didn't understand why they couldn't have come at the right time in the first place". Another relative told us "my mum doesn't go out very often, but she does like to go and see her friends occasionally. It really doesn't help when one morning they can come to help her get up at 8am and the next it will be 10am. She cannot plan for anything when she doesn't know quite when, she will be ready. The office tells me they try to come at a set time that is better for her, but they can't guarantee it". Another person told us "it's really difficult to plan anything when you are told that a visit might be between 8am and 10:30am, therefore I usually ask my carer before she leaves, if she has a rough idea of when she will be back the following day".

The registered manager and staff told us, due to the contract people had with the agency and the local authority, time bandings of visits were given rather than a specific time of the staff member's arrival. For example, a morning visit to assist a person with personal care and their breakfast could be between 7am and 10.30am. A bed time visit could take place from 6.30pm to 10pm. Staff told us they tried to allocate people's visits at the same time each day to ensure consistency. However, this was not always possible. They said people sometimes called the office to say the member of staff was late for their visit. However, if the member of staff was within the specified time band, the agency did not consider they were late. The registered manager confirmed this was often a difficulty, as some people were not aware of the time bands and did not understand the contract they had. They said in addition to working further to enable consistency of visit times, educating people more fully about this, was required.

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

People and their relatives told us they knew how to make a complaint. One relative told us "I certainly know how to make a complaint and in fact I needed to make one after Christmas". The relative continued to tell us that unfortunately, they did not feel their concerns were treated with any real merit. Another relative told us they had met with the registered manager in response to a concern they had raised. They said the registered manager apologized and said they were struggling because they could not recruit the number of staff, they needed. The relative told us as much as they appreciated this, their concern was that their family member had the care they needed.

The registered manager told us all complaints were taken seriously and properly investigated. They said they or a member of staff would visit the person to discuss their concerns and agree a way forward. The registered manager said at the beginning of April 2016, a letter of apology had been sent to people who used the service. This was to apologize for any inconvenience caused from the disruption to visits, which were encountered because of staff shortages. There was a file, which contained written records of formal complaints, which had been made. However, the information was difficult to follow. This was because the records were often a series of emails, which did not clarify the complaint or the outcome reached. This did not enable complaints to be used as a learning experience, to minimize future occurrences or to improve the service.

Is the service well-led?

Our findings

At the last comprehensive inspection, which took place in January and February 2015, we identified the service was not meeting Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because auditing systems were not in place to assess the quality of the service and potential risks to people's health, welfare and safety. In addition, people did not feel listened to and were reluctant to raise their concerns, as a result. After the inspection, the provider sent us a written plan, which stated the actions that would be taken, to ensure improvement. We undertook another inspection in September 2015 to make sure the action plan was being followed. Immediate action had been taken to address shortfalls. However, at this inspection, the improvements had not been sustained.

The registered manager started employment at the service in July 2015. They were supported by a team manager and a team of coordinators and field supervisors. The registered manager had relocated their office from downstairs, to be near the staff team. They said this enabled better communication and an oversight of the day to day work being undertaken. The registered manager told us they were aware the agency was not performing, as they wanted it to. They confirmed the main contributory factor was insufficient staffing, despite posts being regularly advertised and an open day being held. The registered manager said there were definite challenges with covering people's visits and staff were often "firefighting", rather than developing the service. In addition, some office staff were undertaking people's visits and concentrating on maintaining cover, rather than fulfilling their own role. The impact of this meant they were not supporting and supervising staff efficiently and care packages were not being properly reviewed.

Systems did not enable efficient practice and monitoring of the service. The electronic call monitoring system did not enable missed calls to be easily identified. In addition, visits were not automatically scheduled and routinely repeated each week, to minimise the work involved. There were no schedules to identify when staff needed supervision or an appraisal, to adhere to the required frequency, as stated in the agency's policy. Similarly, there were no checklists or audits to identify when documentation needed to be updated. This included confirmation that staff had the required car insurance and an up to date MOT (Ministry of Transport) certificate to ensure their car's safety. Much of this information within staff personnel files was out of date. During spot checks of staff, there were repeated occasions when it was noted that staff did not have a valid identification badge. The extent of this shortfall had not been identified and there was not a system in place to ensure the badges were appropriately allocated. Furthermore, complaints and safeguarding concerns had not been analysed to identify common themes. This did not minimise future occurrences or enable staff to learn from events.

There was an "on call" system in place for any issues, outside of office hours. Office staff took it in turns to undertake this role. They said each shift varied in the number of calls received. However, if busy, it could be tiring especially after working all day in the office. Records of the "on call" system showed there were regularly 20 calls made, spanning the whole evening. This indicated potential shortfalls in service provision or a lack of clear guidance about the use of the "on call" system.

Staff swiped their electronic monitoring system when they arrived at a person's property. If they failed to do

this, the call monitoring centre in Belfast would contact the member of staff to see where they were. This minimised the risk of missed calls. However, agency staff did not have the electric monitoring system, which meant their work was not monitored and the completion of calls was not assured. One member of staff told us the call centre would regularly contact the agency member to ensure their whereabouts. Another member of staff told us it was the responsibility of the agency staff to contact the monitoring centre, after each visit had taken place. This indicated there was not a clear procedure in place, to ensure all visits were undertaken as required. The absence of this increased the risk of missed visits.

Some people's visits due to the particular contract held with the local authority, were measured on outcomes rather than time. For example, a person's visit may have been scheduled to take place for half an hour but in practice, it took 20 minutes. Staff told us as long as all outcomes had been met, they were free to leave and not stay for the allocated time. The electronic monitoring system showed staff had generally stayed for the scheduled duration of the visit. However this was not always so, despite staff getting paid for the scheduled length of the visit. There was no system to monitor this practice to ensure people received the service, they required.

The registered manager told us senior managers formally assessed the service on a monthly basis but visited more often for support. They said the most recent audit had only just taken place so records were therefore, not available. The last documented report within the file, was dated September 2015. This did not evidence regular, on-going monitoring of the service. The registered manager told us this was because there had been changes to senior managers, so visits had been inconsistent in frequency. They confirmed this had been addressed and monthly visits would now take place. The last report showed shortfalls in areas such as staff recruitment and health and safety. These issues had been identified in previous reports but had not been addressed. After the inspection, a senior manager sent us a copy of the most recent audit undertaken at the end of April 2016. This showed an audit of various records and discussions with staff and people who used the service, regarding service provision.

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

The registered manager told us the organisation's quality and performance manager had undertaken calls to people, to gain their views about the service. The registered manager told us these findings had not been coordinated so were not available during the inspection. However, after the inspection, a senior manager sent us a report of the summarised findings. The report showed the calls were undertaken between 12 May and 15 June 2015. A total of 148 out of 196 people were spoken with and 130 people participated within the survey. The report showed people were positive about the staff who supported them. The area which caused the least satisfaction was the punctuality of visits. Recommended actions had been agreed although there were no details of timescales or who would be responsible for undertaking the work. The registered manager told us the office staff would usually make further calls and visit people, to monitor the quality of the service. However, due to staffing shortages, these had not taken place, as much as they should have done. The registered manager said this was because priority had been given to ensuring people's visits were properly scheduled.

There were concerns from some people about the management and day to day organisation of the service. One person told us "if it weren't for the fact my regular carers have been coming for some years, I would've left the agency long ago, as I'm fed up with having to phone and find out what time my carer is likely to be here". Another person told us "if it weren't for my lovely regular carers, I wouldn't be with the agency at all, as I've got completely fed up and would have gone elsewhere by now". Another person told us "I don't get a rota anymore, because it was so often changed at the last minute that it wasn't worth them paying the price

of a stamp to send it. My carer is much more reliable with information than the office ever are".

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not being safely managed. Records did not show an accurate account of people's medicines. Staff had not signed the medicine administration charts and had not received up to date training. The service was not always responsive to people's needs with some concern about the consistency of visits. Support plans were limited in their detail and key issues were not being identified and addressed.
Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People's safety was not assured as staff were not following the correct procedures, when they were not able to gain access to properties. Risks were not being properly identified as assessments were not being regularly reviewed. Not all staff had received up to date training in keeping people safe.
Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems did not enable efficient practice and monitoring of the service. Shortfalls were not being identified or addressed.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was insufficient staff to meet people's needs effectively. This gave inconsistently and increased the risk of late or missed calls. Not all staff had received training, support and supervision as detailed within the agency's policy.