SCC Agency limited

SCC Agency Ltd (trading as South Coast Care)

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?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 8 and 12 January 2015 and was unannounced. The service provides personal care to approximately 120 people living in the West Sussex area. The service has a registered manager in place, who had registered with CQC in April 2013. 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.

At the last inspection on 5 August 2014, we issued two warning notices requiring the provider to make improvements to the care and welfare of people and to the assessing and monitoring of service provision by 31

Summary of findings

October 2014. We also asked the provider to take action to improve the safeguarding of people who use the service and in supporting workers. The provider sent us an action plan on 18 October 2014 stating they were now meeting the requirements of the regulations. We found the provider had improved the safeguarding of people using the service. However, they had not made the

necessary improvements to the other areas of concern and were not meeting the requirements of the Regulations.

People's safety was compromised in some areas. Some care plans had been rewritten and risk assessments updated but care plans still did not reflect people's individual needs. Risks were not assessed accurately and action was not recorded for care staff to reduce the risk. Where challenging behaviour had been identified this had not been adequately assessed in order for staff to provide appropriate care that met people's needs and protected their rights.

Medicines were not managed safely. Risk assessments failed to identify risks effectively and staff did not follow guidance relating to the safe use of medicines.

Recruitment processes were not followed as the provider had failed to ensure all necessary staff's checks were carried out before staff commenced employment at the agency. There were sufficient staff to provide care to people who required it. However, some people said they received many different care staff and as a result did not receive continuity of care.

The management team and care staff were not aware of how the Mental Capacity Act 2005 affected their provision of care to people. This placed people who lacked capacity to make decisions at risk of not receiving the support they required in order for care to be provided in their best interests. Staff monitored people's health and took action where appropriate, however, often people's care plans failed to mention key health information relating to the person.

Staff did not receive regular and effective supervision. They had not completed training to equip them with the skills to meet people's needs in the most effective way. People were not always involved in the planning of their care and their feedback was often not sought and acted on.

People said they knew how to make a complaint and records showed formal complaints had been responded to according to the agency's policy. At other times the agency had failed to respond to people's concerns, and people said they had found the management to be unresponsive.

Most people said their care needs were met and care staff demonstrated an understanding of people's needs and how to meet them. Care staff showed a kind and patient manner and people said they felt safe with care staff. They were complimentary about the friendliness and helpfulness of care staff. Staff were aware of local safeguarding procedures and felt confident to use them. They demonstrated knowledge of what constituted abuse and their responsibilities in relation to reporting their concerns.

Staff said the management team was open and supportive. However, the management team were unfamiliar with the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Essential Standards of Quality and Safety. Quality monitoring processes in place had failed to identify when care staff did not stay for the scheduled amount of time to provide care. They had also had not highlighted the breaches of regulation found at this inspection. As a result action had not been taken to ensure the regulations were met.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risk assessments were not completed fully and did not mitigate risks to people's health and safety. Care plans were not fully developed and measures put in place to manage people's needs.

Medicines were not managed safely and recruitment practices were not robust to ensure the fitness of staff to carry out their role.

Staff knew how to recognise and report abuse. There were enough staff to care for people's needs.

Is the service effective?

Inadequate

The service was not effective.

Management and staff lacked an understanding of the Mental Capacity Act 2005 and how the principles should affect their treatment of people who may lack the capacity to make decisions.

Staff were not supported through regular supervision of their work. Key training had not been completed which may impact on care people received. Staff competency was not assessed following training.

Staff monitored people's health and took appropriate action where healthcare support was needed.

Is the service caring?

Requires improvement

The service was not always caring.

People were not always involved in the planning of care, or informed which care staff would be providing their care. People said staff were kind and provided care in a respectful manner.

Staff showed consideration for people's wellbeing but they did not always take care to protect people's privacy and dignity.

Staff were aware of people's needs but did not always know how to meet the needs of people with behaviour that could challenge.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's care plans were insufficiently detailed, task focussed and not personalised.

The agency was not always able to respond to people's changing needs because they did not seek people's feedback on the service they received

Summary of findings

People knew how to raise any concerns or complaints and they felt confident these would be taken seriously.

Is the service well-led?

Requires improvement

The service was not always well-led.

The agency had a registered manager and staff were supported by the management team. However, the management team was not effective and was unsure of their role and responsibilities.

Systems in place to monitor the quality of the service were ineffective and had not identified breaches of regulation. Audits had failed to identify areas of poor service and as a result improvements were not made.

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Detailed findings

Background to this inspection

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

This inspection took place on 8 and 12 January 2015 and the first day was unannounced. The inspection team consisted of two adult social care inspectors and an Expert by Experience – this is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the previous inspection report and information we held about the service including notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 16 people using the service and eight relatives. We also spoke with the registered manager, deputy manager, eight care staff and two office staff. We accompanied one care staff to the homes of three people to speak with them and to monitor the care they received. We looked at care plans and associated records for 10 people, staff duty records, three recruitment files, records of complaints, accidents and incidents, medicines administration records, staff meeting minutes and the provider's policies, procedures and quality assurance records.

Inadequate

Is the service safe?

Our findings

At our last inspection on 5 and 6 August 2014, we found the service was in breach of regulations 9 and 11. Care and treatment was not always planned and delivered in a way that ensured people's safety and welfare. People were at risk of not receiving the care they required and risks were not adequately assessed and action plans developed to mitigate them. We issued a warning notice and required the provider to make improvements by 31 October 2014. We also asked the provider to take action to ensure people were protected from the risk of abuse and appropriate action was taken when concerns were raised about people using the service. At this inspection we found the provider had made improvements with regard to safeguarding people who use the service. However, the requirements of the warning notice had not been met.

All care plans had risk assessments but these were not always relevant to the person and did not specify actions required to reduce the risk. None of the ten risk assessments had been completed in full. One person's care plan failed to draw attention to health issues identified in the risk assessment which required monitoring. It also did not refer to their oral care, or that they required their spectacles and a walking stick in order to mobilise safely. Another person's care plan did not refer to when they required continence support for their occasional incontinence or that they were susceptible to infection, both of which had been identified in their risk assessment.

Another person had a history of falls and had been assessed as at further risk of falling. No mitigating action was recorded and their care plan contained no information about how care staff should assist the person safely to reduce the risk of them falling. Another person's care file showed they had reduced mobility. The risk of pressure injury and infection or action staff should take to minimise those risks for someone with reduced mobility were not addressed in either the risk assessment or care plan.

Where information had been received from the organisation referring the person for care by the agency, this had not been transferred to their care plan. This meant staff did not have access to key information on how to care for the person in the most effective way.

As a result of the issues above people were put at risk of unsafe care because risks to their health and safety had not been assessed and managed appropriately.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The recruitment process in place did not ensure checks on staff suitability were carried out before staff commenced working. Three staff files showed that staff started work before employment references had been received. For one of the staff, the person who had provided the reference differed from that given on the staff application form. At the time of the inspection, references had been obtained. The registered manager said they had found it difficult to get written references and had received telephone references. However, there were no transcripts of these conversations to support this.

The provider was not able to demonstrate that new staff were supervised if they started work before a check with the Disclosure and Barring Service (DBS) had been received. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. For one member of staff their DBS check was dated three weeks after the date they started work for the agency. The staff member told us they had shadowed another member of staff for two days and attended a meeting before they started working alone. No record was available of how the staff member was monitored or supervised during this period.

The provider's recruitment process did not follow the agency's recruitment policy or procedures and regulations relating to staff checks.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines management practices were not safe. We observed one person being supported to receive eye ointment and eye drops. The manufacturer's instruction stated that the medicines should be discarded within 28 days of opening. However, the date of opening had not been recorded on the boxes. The member of staff administering the medicine did not know when it had been

Inadequate

Is the service safe?

opened and the date could not be established from either the daily records of care, or the Medication Administration Record (MAR). Therefore it could not be known whether the medicines was safe to be used or were out of date.

Another person's MAR showed they were prescribed medicines to be administered by care staff at 8am. However, care staff were scheduled to visit the person at 10:30am, and records showed on occasion, the calls were later than 10:30am. This meant the person did not receive their medicine at the prescribed time. For another person who was prescribed paracetamol there was no plan in place to ensure that adequate time between care staff calls was allowed. We noted that on occasion, the paracetamol was administered at less than the recommended four to six hour intervals.

Another person's medicines risk assessment stated they were at risk of overdose if they administered their own medicines and therefore their medicines had been kept in a secure place. Staff told us, and the person's care plan stated, "blister pack medication is kept on the chair in the lounge". The medicines risk assessment had not been updated and the risk was not mitigated. Medicines were not kept safely and this placed the person at risk of harm due to mismanagement.

The above issues placed people at risk of harm because medicines were not managed safely.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People said they received the care they required each day. One person said, "I'm very satisfied with the service, they're very good". Another commented, "it all works well".

People said they felt safe with staff. They said they would contact the office if they felt there was something making them feel unsafe. Information on how to do this was included in the guide left in each person's home.

Staff knew about safeguarding people against abuse and what to look for if they felt a person was at risk of abuse. They were aware of their responsibilities and were familiar with local authority safeguarding procedures and how to use them. One staff member said, "the client's wellbeing and happiness come first". Where care staff made financial transactions for people, these were recorded to protect people from financial abuse. All staff had received training in the safeguarding of adults at their induction and updates following this.

There were enough staff to ensure people received their care. A sample of weekly rotas for three people showed named staff scheduled to call at a time based on their preferred time as recorded in their care plan. Staff told us they had regular calls to provide care to the same people which meant people received a consistent service. Staff said they had sufficient time to travel between calls and this allowed them to be able to respond If there was a change to someone's needs, or new people requiring the service. People we spoke with had no complaints about the times staff arrived. One person said, "overall, I'd say they are good at time-keeping".

There were plans to deal with foreseeable emergencies. Staff were aware of the contingency plan in the event of severe weather which may affect their ability to reach everyone that needed care. In addition the plan covered computer failure and excessive sickness amongst care staff. If staff were not able to access a person's home they took appropriate action to check the person was safe and well.

Inadequate

Is the service effective?

Our findings

At our last inspection on 5 and 6 August 2014, we found the service was in breach of regulation 23 which related to supporting staff. Staff supervision was not effective or regular for some staff. We asked the provider to take action to improve the standard of support available to staff. On 18 October 2014 the provider sent us an action plan stating they had addressed the breach of regulation and were now compliant.

At this inspection, the provider had not made the required improvements. The majority of staff had not received an appraisal during the time they had worked at the agency. The registered manager did not have a clear overall assessment of staff training or a plan of future staff training needs. They said many people using the service were developing dementia, yet only 17 of the 51 staff were recorded as having received training in the care of people with dementia. One member of staff, who had not received the training, said they had experienced difficulties in providing care to a person with dementia. A relative told us, "some of the carers don't seem to be trained to support people with dementia". As a result people with dementia may not receive appropriate, personalised care to meet their needs.

The agency provided care to a number of people who exhibited challenging behaviour. A policy was in place which stated 'care workers will have challenging behaviour training if providing care to customers who have or may be prone to have challenging behaviour'. Staff said they had not been trained to provide support to people with challenging behaviour. Multiple incidents of challenging behaviour were recorded for one person using the service. No records were kept of the support provided, either to the staff member or the person receiving care. Staff were not supported with appropriate training to provide effective care to people with challenging behaviour.

Records showed new staff did not receive regular supervision to monitor their work and assess their skills. The registered manager said they aimed for two individual supervisions and two spot checks for each member of staff within a 12 month period. During this period two staff had not received any supervision, 16 had received one and 13 of those had been employed by the agency for more than six months. Two staff had received three supervisions, however there was no evidence that new staff had extra supervision to ensure they applied their training and had the skills necessary to provide appropriate care. Staff were unsure about the level of support they could expect. One care staff said they had spot checks but no supervision. Another thought they had supervision every three months. One senior member of staff said they had not received any feedback on their work.

Where staff had received training, their competency had not been adequately assessed. For example, there was no detailed record to demonstrate staff competence had been assessed following training in the administration of medicines. Staff said the training took the form of watching a DVD and filling in a questionnaire. No practical training or assessment of competency was carried out. A senior member of staff was designated as the trainer in moving and handling for all staff. Although the theory was covered in new staff induction, there was no practical training. Staff told us they observed experienced care staff whilst shadowing them and were signed off as competent at the end of the observation. This meant new staff were only partly trained and assessed in moving and handling by unqualified staff. A new care worker had been signed off as competent for all areas of care delivery including moving and handling after training in the office over two days and four hours of shadowing. This lack of practical training in moving and handling put people at risk of poor and unsafe care. The registered manager agreed this was not sufficient time for the new staff member to be shown what to do and be assessed. The staff member had received one spot check and one supervision session since their induction. The record was not sufficiently detailed to ascertain what had been checked.

The provider failed to ensure that staff were appropriately trained to equip them with the skills and expertise to provide safe and effective care.

The issues above are a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff were not familiar with the principles of the Mental Capacity Act (MCA) 2005. The MCA aims to protect people who lack capacity, and maximise their ability to make decisions or participate in decisions that affect them. Care staff understood that they should gain consent from people before providing care, and if they refused care, staff

Is the service effective?

recorded this. However, three care staff were not clear about what to do if people had difficulty making decisions. They did not know when the MCA affected their work and how this was relevant to people's decision making ability.

The registered manager was unclear about the nature of the responsibilities of a power of attorney (POA) for a person using the service. A POA is a legal authorisation to represent or act on someone's behalf who does not have the capacity to do so. They did not know if the POA covered finances, care and welfare or both, or if the POA had been registered. They said the person's care plan had been agreed with the POA, however records showed that the risk assessments and not the care plan had been signed by the POA. A lack of capacity to make decisions had been assumed without formal assessment of the person's ability to decide for themselves whether they wanted the care and how they wanted it delivered.

A lack of understanding and application of the MCA Code of Practice meant appropriate assessments and support were not in place when a person did not have the capacity to make a decision. This failed to protect people from receiving inappropriate care.

The issues above are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Where care staff were responsible for helping people to eat and drink, staff supported them appropriately. The amount of help given varied from person to person and this was recorded in people's care plans. Some people required assistance to prepare food; other people preferred staff to make meals for them. Staff recorded what people had eaten and drunk and if they had refused the meal. Staff recognised that monitoring people's health was part of their day to day responsibilities. They gave an example of monitoring people's skin integrity. One member of staff said if they were unsure of a person's health they would check the daily care notes, check with the person's family, call a District Nurse if appropriate, or contact the agency office. One staff member told us they had reported to the office that a person was experiencing back pain and had reduced mobility and requested an additional visit to the person to monitor their wellbeing. This was promptly followed up with a further visit and additional support was arranged from an Occupational Therapist.

Requires improvement

Is the service caring?

Our findings

People's views varied on their involvement with the planning of their care. One person receiving care said, "They sent me a risk assessment for signing; they'd written it themselves without input from me and they just told me to 'sign here'". A relative said, "a care plan was developed with a very helpful supervisor from the service, which in the main is working OK". Where people had dementia, there were no records to show family members and people who knew them well had been consulted about the person's values or wishes in relation to their care. Consequently, people may not have been receiving care and treatment in the way they wished to receive it.

Two of the four care plans held in people's homes were not dated and none were signed. Of the six care plans held in the provider's office, two were not signed and four were not dated or signed. It was therefore not possible to confirm who had been involved in the care planning or when they were written.

Staff recorded the care they delivered at each call. A sample of these records showed they were dated, timed and signed by each member of staff each time they visited the person. However, where care was delivered to a couple this was recorded in a joint record. This could have compromised each other's privacy and confidentiality.

One person complained about the lack of conversation with staff when they provided care and described a task centred approach by staff. A relative said, "Some of the carers call [their relative] 'sweetie' or 'love' when she wants to be called by her real name and gets annoyed when they don't". People did not always receive care that protected their privacy and dignity.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Most people said staff were caring. One person said, "they look after me pretty well; they are all polite and respectful". Another person was positive about the way care was delivered and said, "the staff are very good". Other comments we heard about the staff were, "care ticks over – no complaints", "the carers are all very nice…they have a nice chat with [their relative]", "the girls are all friendly", "they are first class", and, "the carers are fine; I'm happy with them". Another person said, "I would recommend them to anybody". One person said they were supported to do what they could independently when they received care.

Staff told us they mostly made regular calls to provide care to the same people. This helped them to get to know the person they were caring for better and really understand their individual needs. They said they were usually introduced to a new person before their first visit to provide care, but this was not always possible if the call was urgent. One staff member said they had communication difficulties when providing care to a person with dementia. They said they needed to "sit and listen" and "watch gestures and prompts" from the person. They assisted the person with food choices by showing them the options available. Staff said sufficient time was available to ensure the person received individualised care.

People's views varied on the consistency of care staff provided by the agency. Whilst one person said they were told which care staff would be attending to their needs, three people and a relative told us they were not informed who would be providing care. One person said, "I don't know who is coming as it could be any of four or five carers; I don't receive a rota". Another person said, "the latest rota shows 14 shifts with 10 different carers."

We visited four people in their homes with a member of staff who was delivering care at lunchtime. The staff member interacted positively with people. Although they said they mostly provided care to people in a different geographical area, they demonstrated knowledge of people's needs and the key tasks for each call. Staff showed an understanding of equality and diversity and were able to give examples of when they had taken diversity into account. One of these involved a person with a sight impairment. The staff member had taken additional steps to ensure the person's needs were met. When people called the office we heard office staff talking with people in a kind and caring manner. They were patient when people experienced difficulty understanding and spoke slowly and clearly when this was necessary.

Staff showed they cared about people's wellbeing. One member of staff said a person they cared for told them their heating had broken. The staff member ensured the person had enough blankets and hot drinks and were comfortable until the heating could be fixed.

Requires improvement

Is the service responsive?

Our findings

At our last inspection on 5 and 6 August 2014, we found the service was in breach of regulation 9. Care and treatment was not always planned and delivered in a way that ensured people's safety and welfare. People were at risk of not receiving the care they required and risks were not adequately assessed and mitigated. We issued a warning notice and required the provider to make improvements by 31 October 2014. At this inspection we found the provider had not met the requirements of the warning notice.

None of the ten care plans contained a personal history of the person they referred to. The majority were task focussed and did not reflect the individual needs of people requiring care. Staff showed an understanding of person-centred care but documentation available to them such as risk assessments and care plans left them at risk of not providing the support people required.

Where a person receiving care was prone to challenging behaviour, the agency's policy stated the person's care plan would be include an assessment of the behaviour including 'trigger points; likes/dislikes; personal hygiene consideration; environmental triggers'. The care records for people identified as exhibiting challenging behaviour did not contain this information. People's specific needs had not been assessed in a way that would assist staff to provide care in the most effective way.

The registered manager said they had reviewed all the care plans in the previous five months. However, we found care plans were not person-centred or detailed as to people's individual choices and preferences.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Where people had requested changes to the timing of their calls these had mostly been accommodated by the agency. However, people were not routinely asked for feedback and so changes were not made to people's care in line with their needs and preferences. One person said, "I asked them to come at 9:30am but they started coming at 10:45am which was no good for me. I called the office and they sorted it". A relative said, "they seem quite flexible in making changes. Sometimes I have to rearrange care and they work around our timings". Of the five people and relatives who commented on the timing of care calls, three told us they were not happy with the service. One person said they felt 10:30am was too late for a breakfast call. Records showed their breakfast call was sometimes earlier and sometimes later than 10:30am. Their lunchtime call, where a meal was provided, was scheduled for 1:00pm. The person said they preferred this to be later. Another person said weekend calls were a problem, commenting that support, "should be 8:45am" but is usually, "after 10".

One person said "the carers are rushing, and trying to get out of the house and on to the next job as quickly as they can; they are not spending sufficient time". Several people complained that care staff were not staying the right length of time. One person said staff who were scheduled to spend 30 minutes providing care often spent only 10 or 15 minutes with them.

Staff said they had enough time to provide care without rushing and that travel time between calls was usually sufficient. The staff we observed providing care was late for two of the four calls they made. They told us they would usually inform the person they were going to be late, however in these cases the people would not answer the telephone. Both people said they did not mind the call being late.

There were examples of how the agency had responded to people's changing needs. The registered manager said one person receiving care was left without sufficient food. Staff liaised with the relatives of the person and assisted them to organise an online shop. This arrangement meant the person now had regular deliveries of food to their home. Another person was noted to be sleeping in an armchair each night. Staff liaised with the local Occupational Therapy team which resulted in the purchase of a reclining chair which better suited the person's needs. In another case a person was not eating sufficiently because the meal provider delivered the meal too early in the day for them. Staff at the agency provided information regarding an alternative which could be delivered at a more suitable time. This resulted in the person eating their meal more regularly.

People knew how to make a complaint. This was outlined in the service user guide each person receiving care was given. This included who to contact if they were not satisfied with the outcome of a complaint. Most people said they could talk to staff if they had concerns and felt confident to do so. They said they thought issues would be addressed. A relative said they had complained about the

Requires improvement

Is the service responsive?

quality of the skills demonstrated by one member of staff. The registered manager had provided a letter of action they would take in response and the matter was resolved to the relative's satisfaction. Records showed the registered manager had addressed the matter appropriately.

Two people said they did not get a satisfactory response when contacting the agency office with a concern. A relative said they "never phone me back" when they call the office and complained that agency staff were "not very responsive to the problems I've had". People did not always felt they were listened to when they raised concerns. Although staff said they always passed on people's concerns to the office staff these were not used by the management as an opportunity for learning or improving practice.

Requires improvement

Is the service well-led?

Our findings

At our last inspection on 5 and 6 August 2014, we identified breaches of four regulations. We issued warning notices requiring the provider to make improvements to the care and welfare of people and the assessing and monitoring the quality of care provision. We also asked the provider to take action to make improvements to the safeguarding of people who use the service, and the quality of support provided to staff. The provider sent us an action plan on 18 October 2014 stating they had addressed all areas of concern and were now meeting the requirements of the regulations.

At this inspection, we found the provider had addressed one of the areas of concern, but had not met the requirements of the warning notices or taken action to address the other areas of concern. This demonstrated that the provider had not taken action to meet the essential standards. Concerns which had been highlighted to the management team had not been addressed adequately.

The agency had a registered manager and a deputy manager. Neither were able to demonstrate an understanding of the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, and were not familiar with the Essential Standards of Quality and Safety. The registered manager failed to monitor the service effectively and as a result was not aware of the breaches of regulations identified at this inspection. Therefore, improvements to the service people received had not been made.

The registered manager said they had recently started quality monitoring visits to people using the service. Whilst some aspects of care delivery were discussed, no monitoring of the effectiveness of the risk assessment in relation to the care plan and care delivery was carried out. Nor were Medicines Administration Records (MARs) checked for accuracy and completeness. The person's risk assessment and care plan were not complete, but these documents were not checked at the visit. Therefore the additional quality assurance visit was not fully effective in monitoring the service provided, and areas for improvement were not addressed.

An electronic call monitoring system failed to identify when care staff did not stay the scheduled length of time at a person's home. The electronic record showed multiple occasions when care staff had not stayed for the full duration of the call. Some calls, scheduled for 30 minutes, were less than 20 minutes and two were less than 15 minutes. No comments had been recorded as to why care staff had left spent less time than scheduled in the person's home on any of the occasions. Staff also recorded their arrival and departure time in the daily records of care. This issue had not been picked up by the provider's internal audits of records and the registered manager was not aware of the shortfalls in the length of time staff were spending with people. Therefore the quality of the care provided to the person had not been discussed with either the care staff concerned, or with the person using the service. There was no effective system in place to monitor the quality of the service provided to people.

One person's care file contained eight emails which had been sent to inform them that the care staff scheduled to provide care to them had changed at short notice. The eight changes occurred over a period of seven weeks. The person had a core group of five care staff who provided their care and in four of the eight occurrences the change involved a member of staff who was not part of the core group of regular care staff. The person had stated in an email to the agency that they "did not like meeting new people", and that they "did not recognise one of the names" on their rota. The registered manager was unaware of the multiple changes to the person's rota and told us the person "only gets a regular team of care staff". There was no effective system in place to regularly assess changes to staff rotas. As a result people using the service did not always receive consistent staff to provide care and this was not identified or addressed by the quality monitoring system.

Audits carried out by the registered manager had not identified issues we found with care plans, risk assessments, MAR charts and daily records of care provided. As a result errors and omissions were not addressed. The auditing system was not effective and did not identify the shortfalls in care provision.

These issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Some records relating to people's care and staffing were not accessible. Daily records of care for one person were not available for the previous four months. The registered

Requires improvement

Is the service well-led?

manager said both the length and time of the calls had changed since the person's first assessment but there were no records available to view to confirm they were receiving care appropriately.

Records relating to three medicines errors involving two care staff had been archived. Archived records were kept in a side room of the building. These were in boxes which were piled high and not labelled. The records were therefore not accessible and could not be located quickly if required.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff said they felt supported by the management team, and were given feedback about their work. They felt able to own up to mistakes and were confident they would be supported. Information was communicated to them through staff meetings, supervision and spot checks, as well as working alongside other staff. One staff member said they had confidence in the office staff, adding, "that's the first company I can say that about". Another staff member said the management were friendly and approachable. When they needed advice office staff, or on-call staff, were quick to respond. Other comments about the management included, "I have always had good support from the team" and, "if I have a health appointment they always arrange things so I can go".

Some people had been asked for feedback on the service provided, records showed people were mostly satisfied with their care. Where issues had been raised the registered manager said these had been addressed. However, there was no documentation to confirm this or action plan developed to address these.

The agency had a set of values and two staff we spoke with were able to identify these and demonstrate how they affected their work. The registered manager said they had discussed the previous Care Quality Commission visit and the breaches of regulation identified at the inspection. Minutes of staff meetings confirmed this. Records also showed the issues had been addressed with supervisors and these were followed up at weekly meetings by the registered manager. However, these measures had not resulted in an improvement to the service.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Appropriate arrangements were not in place so that all people received medicines safely when they were required. Regulation 13

Regulated activity	Regulation
Personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services People were not always involved in the planning of their care, and their views were not sought on their care provision. Regulation 17 (1) (a) (b) (c) (i) (ii)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Management and staff were not aware of the application of the Mental Capacity Act 2005. Arrangements were not in place to ensure people who lacked capacity to make decisions were cared for appropriately and in their best interests. Regulation 18

Regulated activity	Regulation
Personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Records were not accurate, up to date or accessible.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	Regulation 20 (1) (a) (b) (ii) (2) (a)

Regulated activity	Regulation
Personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers Security and background checks to ensure staff were suitable to work in the provision of care were not carried out before staff commenced work. Regulation 21 (a) (i) (ii) (b)

Regulated activity	Regulation
Personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Staff were not supported to care for people safely and appropriately because training was not provided to equip them with the skills they required. Regulation 23 (1) (a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not protected against the risks of inappropriate care because care and support plans, and risk assessments, were not always up to date and relevant to the people's individual needs. Regulation 9 (1) (a) (b) (i) (ii)

The enforcement action we took:
We issued a warning notice which the provider must comply with by 31st March 2015.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision Arrangements for assessing and monitoring the quality of service provision were not effective. Regulation 10 (1) (a) (b) (2) (b) (iii) (v)

The enforcement action we took:
We issued a warning notice which the provider must comply with by 31st March 2015.