Firstpoint Homecare Limited

Firstpoint Homecare – Leicester

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an announced comprehensive inspection of Firstpoint Homecare - Leicester on 9 January 2018. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults and younger disabled adults. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in. At the time of inspection thirty six people were using the service. The service was previously registered at another address. They had moved location and re-registered in October 2017.

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

People were not protected from abuse. People told us that staff were often late for calls and that they had missed calls completely. We found that there had been missed calls. The irregularity of visits meant that people did not receive the care they needed. This is neglectful practice but had not been recognised as such by the registered manager or provider. Incidents of missed calls had not been reported or investigated appropriately. There was no monitoring in place to ensure people received their care despite people having raised this consistently through their feedback to the service.

People's care was provided by staff who had received some training and support to carry out their roles. Staff had been provided with safeguarding training to enable them to recognise signs and symptoms of abuse and how to report them. However, the potential neglectful practices taking place due to missed or late visits were not recognised or reported.

There were not enough staff deployed to meet the needs of the people who used the service. Staff were often late to visits and sometimes missed these completely as they were visiting other people.

People's medicines were not recorded adequately to ensure staff knew what medicines they had given. The provider had a form which was used in other branches which was more detailed and agreed to implement this. People did not always receive their medicine when they should due to staff not arriving for visits or being late.

People were not adequately monitored where they were at risk of poor nutrition and hydration.

People were not always treated with dignity and respect. This was due to them not receiving the care they needed. People's preferences about staff were not respected.

There was a complaints procedure in place. However people and their relatives felt that their concerns were

not listened to. Where people had raised concerns these had not been recognised as a complaint, investigated or responded to.

People did not always receive their care at the times they preferred. Staff did not always arrive at the time specified on the rota or stay the whole allocated time.

People's views were listened to; action was not taken to address their concerns when they provided feedback.

There were insufficient systems in place to assess and monitor and improve the service. Where the registered manager had identified issues with the quality of the service they had failed to implement changes

People were protected from the risk of infection by staff that complied with the provider's infection prevention policy.

People were assessed for risks associated with them receiving care and had care plans to mitigate their known risks. They were supported to access healthcare services.

Staff ensured that people consented to receiving care. People were supported to have choice about their care.

People felt they built good relationships with staff who knew them well when they were supported by these staff.

People's personal information was kept secure to maintain their confidentiality.

People had been involved in developing their care plan and reviewing this.

This is the first time under this registration the service has been rated Requires Improvement.

We identified the provider was in breach of seven of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People could not be assured that there were sufficient systems in place to safeguard people from abuse. Staff were not sufficiently deployed to meet people's needs.

Missed calls had not been identified as poor practice and had not been monitored or reported appropriately.

People had risk assessments in place to reduce the potential risks to them of receiving care. The provider followed safe recruitment practices.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People who needed their food intake recording to maintain a healthy diet were not monitored. Records were not kept of what they had eaten.

People were cared for by staff who received some training and support they required to carry out their roles.

People's consent was sought before staff provided care.

People were supported to access healthcare services.

Is the service caring?

Requires Improvement

The service was not caring.

People did not always receive care that was personalised to their needs and preferences.

People were not always treated with dignity and respect.

People were supported to be involved in planning their care.

People had developed good relationships when they were supported by consistent staff.

Is the service responsive?

Requires Improvement

The service was not responsive.

People did not always receive care that met their needs as they did not receive all of their visits.

People had information on how to make complaints and the provider had systems in place to deal with the complaints. However, people's complaints were not recorded or addressed as they would like. People also felt their complaints were not listened to or addressed.

Is the service well-led?

Requires Improvement

The service was not well led.

Quality assurance systems were in place, however these had not been used effectively to drive improvement in the service.

People had been asked for their feedback, however this had not been acted on to improve the service people received.

The provider had not identified that the shortfalls in the service delivery could be abusive practice. They had not notified the local authority or CQC of these incidents so people could be protected from further potential harm.

Firstpoint Homecare – Leicester

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 checked 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 comprehensive inspection took place on 9 January 2018 by one inspector and an expert by experience and was announced. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of service.

We gave the service two days' notice of the inspection visit because it is a domiciliary care service and we needed to be sure the registered manager would be available to talk to us. This was the first comprehensive inspection since the provider added the location to their registration in October 2016.

Before our inspection, we checked the information we held about the service including statutory notifications. A notification is information about important events which the provider is required to send us by law. We contacted the health and social care commissioners who monitor the care and support of people receiving care from Firstpoint Healthcare - Leicester.

During this inspection we spoke with three people who use the service and five relatives. We also spoke with the registered manager, the compliance manager, the operations director, a care co-ordinator, a senior carer and two members of care staff.

We looked at the care records for five people who used the service including their medication records. We examined other records relating to the management and running of the service. These included four staff recruitment files, quality assurance audits, training information for care staff, call monitoring records, staff duty rotas, meeting minutes and arrangements for managing complaints.

Inadequate

Is the service safe?

Our findings

People told us staff had missed calls or were often late. One person commented, "They were late today. They should have been here at 8:30am. I called the office and it was 10:30. They said someone would be there in 20 minutes. It happens fairly regularly. I have had two missed calls. No one bothers to ring me to let me know." Another person told us, "The staff are meant to be here at 8:30am but it can be anytime up to 11am." A relative told us, "We do not even know if the staff are coming. Sometimes they don't show up or they are so late there is no time to do anything."

The provider had systems in place to monitor if people were receiving their calls. These were not used or monitored and were not effective. The registered manager told us some people had a system in place where staff called to log in when they arrived. They explained most people had refused to have this system in place and the only other way they had to monitor calls was through time sheets staff had completed. The co-ordinator told us only one person had the call monitoring system in place.

We looked at the times staff had arrived and logged in using this system. There were nine times out of 61 calls where staff had logged in they had arrived within fifteen minutes of the planned arrival time. The arrival times for all other calls ranged from two hours and 18 minutes early to one hour and nineteen minutes late.

People told us this had an impact on their care. One person said, "We like to go out each day. If they [staff] are late some days we don't get out. They arrive so close to lunch we miss out on getting some fresh air. Appointments (Including hospital) get messed up when the carers are late, or if we don't know when they are coming." A relative told us, "[Person] is left in their chair for hours because the staff either come too early or late or not at all." Another relative said, "[Person] cannot get out of bed without the staff. I don't even know if the staff are coming. Sometimes they don't show up. Sometimes they are so late they don't have time to do anything."

People and their relative's told us staff did not stay for the correct length of time. One person said, "The staff do not always stay the full length of time." A relative said, "This morning they do not have time to shower [person]. Sometimes they only stay 10 minutes instead of 30." Another relative told us, "They often come and empty the night bag and give [person] a drink and leave. They are supposed to wash and dress [person]."

People told us staff did not correctly record the times or length of visits. A relative said, "When I arrived the staff had written in the book the time they had left. The time hadn't even arrived yet. I took a picture of the time recorded against my watch to show it was wrong." A relative told us, "This morning they came at 8:30am for 10 minutes. They have written it in the book as 9:15am to 9:45am. It is not true." We raised this with the registered manager and operations director. They told us they would investigate who had completed the call and the reason for the discrepancy in the records.

We looked at daily records for people and found they consistently recorded call times as being for the correct length and at the correct time. When compared against the call monitoring records which were

available there were significant differences between the times of visits logged on the system and the duration of these. One call was recorded in the daily notes as taking place from 12- 12:30. The call monitoring system shows this call to have started at 11:34 and lasting for 7 minutes. The call should have been 45 minutes long. Another call was recorded in the notes as taking place one hour after the call monitoring system recorded staff arriving. The daily notes could not be used to show staff were arriving at the correct times or staying for the length of the call.

The operations director had suggested in October 2017 the call monitoring system should be in place for all people. When people had refused the use of this there were no alternative systems considered which people may have been happier to use. There was no call monitoring for other people using the service. The call monitoring in place was not monitored to ensure it was being used correctly by the staff. Following our inspection the operations director confirmed the call monitoring system is now being monitored where people are using this to review the times staff are arriving and logging in to the system.

The provider did not use a system to track late, missed or irregular visits to mitigate any risks to people's health and welfare and ensure they received the support they needed. People were not receiving care in line with their assessed needs. There had not been any attempt to contact people to ensure they were receiving their visits when they needed them. This placed people at risk of harm.

People were at risk of not receiving their medicines as prescribed. One person told us, "The time of my medicine depends on how late the staff are." A relative said, "The staff did not turn up on the evening call. [Person] did not get their evening tablets. It is something to help with pain." Staff had not been deployed to administer medicines at appropriate times. For example one person required their medicine twice each day. Staff recorded a different number of visits in their daily notes. This varied from one visit day to four. The person was supposed to have four visits a day. The daily notes had six days in a two month period where only one visit was recorded. The person was at risk of missing their medicines due to the irregularity of the visits.

There were insufficient systems in place to monitor the safety of medicines management. The registered manager reviewed people's Medicine Administration Record charts weekly when they were returned to the office, however they had not identified any concerns. The chart used simply recorded the number of tablets which were taken. They did not provide details of what medicines each person should be taking. This practice is not in line with NICE guidance as staff were not provided with the information and guidance they need to ensure people received the medicines as prescribed. The operations director told us they had been told to use the charts however they used other more detailed charts within the organisation. They agreed the charts would be detailed so staff knew what medicines they were giving to people. People were at risk of not receiving their prescribed medicines as there were not sufficient systems in place to manage their medicines.

The provider had failed to ensure people were protected and provide their care in a safe way. They had not put measures in place to reduce the risk to people of not receiving their care. These matters constituted a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and treatment.

People were not protected from harm or improper treatment. They were put at risk of neglect and degrading treatment due to missed and late calls. One person said, "When staff are late in the morning I am waiting for my catheter to be emptied. It is full and I have to wait more than an hour." A relative told us, "[Person] is supposed to have a shower. We agreed at a meeting they would have a shower every Wednesday and Saturday. It has been two weeks since the last shower. We should be able to rely on the staff arriving."

Another relative commented, "There have been several missed calls. Often I end up as the second carer. It is a recurring problem they don't stay for the full time. They sometimes give [person] a quick check on the front and miss the fact they have a dirty pad or the back is wet." Another relative said, "We expected the carer at 6:30pm. No one showed up. [Person] was distressed as they needed the toilet. They need two people for this and I am not skilled in physically lifting them safely. I had to tell [person] to wet themselves." They went on to say, "There have been occasions when they have put [person] to bed at 6pm and then not arrived until 11am the following day. Staff have rung us and asked us to put [person] to bed; we are paying them to use the correct equipment and support [person] and they ask us to do it. There have been several missed calls." People were at risk of neglect and acts of omission as they were not receiving care to meet their needs.

The provider had a policy in place for identifying and reporting potential safeguarding incidents. Staff we spoke with demonstrated an understanding of potential types of abuse and the action to take should abuse be suspected. However, where people had experienced missed and late calls these incidents had not been identified by the provider as potential safeguarding concerns. The provider did not have a system to track and monitor missed and late calls despite this being something which had been raised by people through feedback regularly.

People and their relatives told us that they had contacted Firstpoint Homecare Leicester to tell them about missed or late calls. When we reviewed complaints received these had not been recorded, recognised as potential safeguarding, reported or investigated. The provider had not reported these incidences to the Local Authority as a potential safeguarding concern. The provider has a duty to report any safeguarding concerns and to CQC in accordance with statutory notification procedures. This meant that systems and processes were not established and operated to prevent abuse. Following our inspection we raised our concerns with the local authority as a safeguarding concern. The operations director told us they had found some missed calls which had occurred recently and reported these to the local authority and to CQC.

The provider had failed to protect people from abuse or improper treatment. These matters constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment.

Staff were not deployed to safely meet people's needs. One person said, "It worries me how often they are late. They seem to have sudden emergencies all the time. They have not got enough staff." A relative told us, "There are clearly not enough staff. They are always short staffed. Particularly at the weekends; when I ring them up because they are late they say the carer will be another hour. What is the point? [Person] changes their catheter themselves because they are so late." Another relative said, "The timing is for themselves and not for the person. The morning call should be at 7am. They don't come until 8:30. The next carer arrives at 11 to give lunch instead of 12." Daily notes and call logs showed the times of visits varied. For example, one person's first call of the day took place at 9:40am one day and 11:55 other days. There were gaps of between 45 minutes and five hours and thirty minutes between their first morning call and second call of the day.

We reviewed the planned call times for one person for a four week period. The person should have had two staff for each visit. The call records showed two carers were allocated to 52% of visits. There were 12 times when both carers had actually logged into the system to say they were at the visit. This was 11% of planned visits where the required number of staff were actually logged in as being at the visit. From a possible 288 times staff should have logged in as being at the visit there were only 61 times staff had used the system. All other visits were noted as staff forgetting to log in.

A member of staff told us, "We get 5 minutes travel time but it is not enough. The calls were packed onto the rota and we could not fit them all in. People told me the staff were late. I started earlier to try and get to all of

my calls." Another member of staff commented, "We get five minutes which is not possible to travel from one location to the next. I was swapped from one run to another without being given the time to travel over 30 minutes. People then complained we were late."

We reviewed the travel time between locations for calls in one geographic area based on the staff planned rota. Staff had been given 5 minutes to travel between calls. The time it would take varied from 5 minutes to 18 minutes. Where the calls were further apart no additional travel time had been given. The time given to staff to travel between calls was not based on the actual journey or time it would take. The lack of organisation of the rotas meant people waited too long for care or received their care calls too close together.

People told us staff were always rushing. One person said, "The staff will complete tasks if I ask them but I have to be on the ball. They are always in a rush". A relative commented, "The carers may only stay 30 minutes if they are in a hurry. This morning they are hurrying and cannot give [person] a shower. It is meant to be an hour in the morning."

People could not be assured there would be staff deployed at times that met their needs. This is a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

People told us they felt safe with staff; However relatives did not agree with this. One person said, "I feel safe with the staff. There is a lot I wouldn't be able to do without them." A relative told us, "[Person] feels safe with most staff. However, [staff] did nothing to stop [person] from falling. They just stood there staring and did not help the other carer." Another relative said, "I don't feel [person] is safe as I do not even know if they are coming." One relative commented, "I do not know how safe [person] is as it is too unreliable. Sometimes [person] is left lying on a wet sheet in a wet pad and the staff do not notice."

The registered manager carried out checks on accidents and incidents in order to review these and to carry out any actions. Where there were areas for improvement in relation to incidents which had taken place these had been discussed with the operations director. However these had not always been completed. For example, it had been identified in October 2017 medication records and daily logs were not being completed correctly and were not being brought to the office on a regular basis. During our visit some people's daily notes for the months of September, October, November and December were not available as they had not been returned to the office. Actions had not been implemented to resolve this and learning had not been put in place to avoid the same situation happening again which affected the quality of the service delivered to people.

The operations director shared information with the registered manager through emails, supervision and management meetings to try and drive improvement. The information was not always acted on and checks were not completed to ensure actions had been undertaken.

Risk assessments were in place to reduce the likelihood of injury or harm to people. These included people who were at risk of falling. They were completed in a way that allowed people as much freedom as possible, and promoted people's independence. These had been reviewed at least annually or when a person's needs had changed to make sure they remained up to date and reflected changes to their circumstances. People's home environment had been assessed to make sure it was safe for people and for staff.

People could be assured staff had been employed using safe recruitment practices. Staff had undergone criminal records checks with the Disclosure and Barring Service (DBS). The registered manager had obtained other documentation including employment histories and character references which were held in staff files

to show staff were suitable to work with people who used care and support services.

People were protected from the risks of infection by staff following processes to help prevent and control infection. Staff wore uniforms instead of their own clothes so these reduced the spread of infection as they were only used for work purposes. Staff used personal protective equipment such as gloves and aprons when providing personal care and prompts to do so were in each care plan. They received training in infection prevention and food hygiene.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us they felt not all staff were trained. A relative said, "I don't think all of the staff have the right skills or training. It is clear [Staff name] is not trained, they cannot do the basics. We did have a couple of excellent ones but they are not sent anymore." Another relative told us, "Some are good; some don't even know how to put a catheter on. I think they are only trained in washing and dressing." Another relative commented, "Some [staff] are good and have good skills, however others are terrible. I have had to step in and ask one to stop when helping [person]. This is not just on one occasion."

Staff training was based on up to date legislation, standards and best practice. However, the training was completed in a very short time frame. Induction training for staff was completed in two days and all other refresher training was completed in one day each year. The operations director and compliance manager told us initial induction training should take 4 days. The records of staff inductions showed staff had completed their induction in two days. A member of staff confirmed they had two days induction training. They said, "We covered a lot in those days. I only had two days training when I started. I did not do any shadow shifts." Following our inspection the operations director told us they would ensure this was changed so staff had the time to fully learn their roles. They also implemented a monitoring form so staff competence could be checked as part of their induction and to record staff had worked with more experienced staff before they worked alone.

Staff told us they felt some training could be more detailed. They also said they had asked the registered manager to consider offering further training to some carers. One staff member told us, "I told [registered manager] that [staff] needed extra one to one training as they could not do the basics. This didn't happen. There was a lot of training to fit in." they went on to say they thought they had completed training in some key areas such as safeguarding but were not sure exactly what training had been completed. Staff undertook a range of training to ensure their skills were up to date and this was refreshed annually. However, the training covered over 12 separate subjects including safeguarding vulnerable people, fire, health and safety and moving and handling. These were completed in one day for all subjects. We raised this with the operations director and registered manager to see how they evaluated the training to ensure it was effective and staff could be deemed as when covering such a range of subjects in one day. They told us this was the training course which the company used and they believed it was detailed enough to give staff the knowledge and skills needed. The operations director told us after our inspection they would be reviewing the training content. The compliance manager told us staff would have completed courses in areas which were specific to meet people's individual needs such as catheter care. However this training was not recorded as taking place. None of the staff we spoke with required this training so could not confirm this training was available.

The provider had failed to ensure staff received appropriate training to enable them to carry out their duties. These matters constituted a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

Staff received supervision from the registered manager where they could discuss training, policies or any

issues they were unsure of. One member of staff told us "I have had supervision. I do not always feel issues were dealt with." Another staff member commented, "I have not had supervision since I started I was meant to have one. I think all of us could do with being observed. Some staff more than others." The registered manager had a record of the supervision staff had received. This included observed practice, competency checks and an annual appraisal of their work.

People's care was assessed to identify the support they required. The assessment covered people's physical, mental health and social care preferences to enable the service to meet their needs. The registered manager told us they worked closely with health and social care professionals to identify people's needs. This meant staff had the information they needed to understand how to meet people's needs in line with up to date legislation, standards and best practice.

People did not always have the opportunity to eat or drink enough to maintain their health and well-being. One person said, "It is rushed. They heat it and do everything else." Another person commented, "The way [staff] prepares my food is very nice." However, as staff did not turn up at regular times where people relied on staff to provide their meals, they would receive their meals too far apart or too close together. A relative told us, "The staff came at 8:30 to give breakfast and are back at 11 to give lunch." Daily notes showed another person who was supported to have their meals had a visit at 7:20 in the morning. The next visit was recorded as 17:10 that evening. There was a gap of nine hours between the visits. The person should have had a visit at lunchtime and had a hot meal. The same person also had two days where the only visit recorded was at lunch time. The time of this was at 2pm one day and 1pm another day. There are no visits recorded to support the person to have their breakfast. Some people had charts in place to monitor the amount of food they had eaten due to a risk of malnutrition. These records were not completed regularly. For November staff had recorded what the person ate on 10 occasions and nothing for the other days. There was no record of what the person had eaten which meant it was not possible to determine if they were receiving enough to eat and drink.

The provider was aware of the Equality Act; their policies and guidelines reflected this. Care was planned to meet people's needs in relation to their age, sex, culture or religion.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as less restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA.

The registered manager understood their roles in assessing people's mental capacity to make decisions and had included this as part of their initial assessment. However, people had only been assessed as being able to make their own decisions or not. An assessment should only be completed when there is doubt about a person's ability to make a specific decision. Some people had been recorded as having a Lasting Power of Attorney (LPA) to make decisions on their behalf. However, the documentation to show that the person had the legal authority to support this had not been recorded. Where people did have capacity to make day to day decisions staff would provide support that took into account their wishes and seek their consent before providing care. One person told us, "She always asks me first before doing anything." Another person said, "They always ask what I want."

People were supported to access health services when they were needed. One person told us, "The staff will ring up the doctor for me if I ask them. Often I arrange it myself." Another person commented, "[Staff] came

with me to the GP. They never hesitate should I need to someone." A relative said, "They notice if he has a rash or something and tell me straight away." Staff knew the process to follow if a person was unwell. People's medical history and current health needs were documented in their care plan. Daily notes recorded advice from health professionals such as a where a person needed to wear a boot to protect them from developing areas of pressure in their heel.

People were supported by staff to use and access other services and social care professionals. Reviews were held with people and professionals who were involved in their care. Input from other services and professionals' was not always documented clearly in people's files to show things had been followed up such as updating the care plan to reflect that someone now needed specialist equipment.

Requires Improvement

Is the service caring?

Our findings

People were not always treated with dignity and respect. People did not receive their visits at the times they preferred or were expecting staff. One person said "The lateness is frustrating. It impacts on me and [relative]. They should be here at 8:30am but it can be anything up to 11am. We have asked for a rota so we know who is coming into our home but that hasn't happened." A relative told us, "I asked them to at least let us know if they were running late or not coming so we can arrange alternative care, but it hasn't happened." People's care plans recorded the times they should have their visits and the times which had been agreed with them in order to meet their needs. The planned rota did take these times into account. However the actual time staff arrived varied which meant people were not having their care at the times they wanted it.

People were also not always treated with dignity and compassion by the staff. A relative told us, "[Person] has got dementia. They don't seem to see this. Sometimes [person] has wet themselves, they ask if they want a wash or the commode and when they say no the staff just leave [person]." Another relative commented, "[Person] feels like a different person when they have had a shower. It is so important for them. This morning they have arrived too late so [person] cannot have a shower." One relative said, "We found the staff at the call before had hoisted [person] with their clothing all up. Their back was exposed and pants were not pulled up properly."

Relatives told us most of the staff appeared to provide dignity when they provided care and gave examples of ensuring this was done in private and people were covered with towels. However, a relative told us, "[Person] is mostly treated with dignity and compassion. They look after them and don't make [person] feel stupid. However, there have been occasions when staff just pull the sheets off and leave them. The good one's make sure [person] is covered."

Staff had completed training in dignity. They had been observed during their practice to make sure they were providing good quality care which respected people's needs and choices. There had been no issues identified during the training or observed practice. Staff told us they tried to maintain people's dignity by closing the door when people were receiving personal care and asking them before they carried out any care. One staff member said, "I make sure the shower curtain is pulled, curtains are drawn and the door is closed. If I am washing someone I make sure they are covered with a towel."

Staff were not given time to provide care to fully meet people's needs. This was due to them not being given enough time between calls to arrive on time and to stay for the whole length of the call. This impacted on staff's ability to spend the amount of time people had been assessed as needing for their care and for all tasks to be completed.

People and their relatives felt they were not listened to. A relative said, "I have pretty much given up. I have raised things time and time again yet nothing changes. It is not going to change for [person]. They are at the end of their life." Another relative told us, "Nothing happens unless you pester and pester." One relative commented, "Two carers wanted to finish at 6pm instead of 8pm. I said no as [person] would be in bed from

6 until the next morning. I complained but [registered manager] supported the carers." One relative commented, "The agency do not listen."

The provider had failed to treat people with dignity and respect. These matters constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Dignity and respect.

People received care from some staff who knew them well. One person said, "I have one member of staff who comes once a week. [Staff] is very caring. They go above and beyond to support me; whatever I ask they do it." However, another person told us, "I have different staff. Some are good. One or two are not really up to the task." A staff member commented, "People want to see the same staff. It helps us get to know them well and they know us. It is not fair to people they don't get the same staff." Some people had developed positive relationships with staff and were happy with receiving care from them. However they felt staff were rushed and did not always have time to spend with them. One person told us "We have some really good laughs. They always listen." Another person said, "When they have a moment they talk to me." A relative commented, "The majority are caring. They will chat with [person] if they have time."

The care co-ordinator told us where possible the same staff were planned to visit people so they had consistency. However, staff told us this did not happen as they were regularly asked to cover other visits if staff were not available.

The registered manager visited some people in their homes to establish that they were happy with their care or to observe staff practice. One person commented, "[Registered manager] comes out occasionally to ask how things are going. " However, a relative told us, "[Registered manager] came to observe a night carer. They didn't tell us what day they were coming. In the end they came unannounced on the day I had an operation. It was 10pm and I was exhausted. [Registered manager] stayed for an hour. There was a lack of sensitivity." Another relative told us, "We went over everything. Nothing changed though." People had the opportunity to talk about their care and provide feedback about the staff. However, actions were not taken to address areas where people asked for improvements.

People and their relatives had been asked if they had any specific cultural needs, personal beliefs or religion they followed which needed to be considered as part of their care. This was important to ensure staff knew about people's beliefs in order to be able to support them to follow these.

Staff told us they always tried their best for the people they supported, as they wanted them to receive good quality care. One staff member said, "I do what I can for people. They are why I come to work. I enjoy working with the people."

People and their representatives had been involved in writing their care plans with the registered manager or staff. One person said, "[Registered manager] came out and went through it all with me." People signed to say they had agreed to their care plans.

People could be assured that information about them was treated confidentially and respected by staff. Information about people was shared on a need to know basis and with their agreement. Records relating to people's care and support were stored securely in filing cabinets. Computers were password protected to promote confidentiality.

Requires Improvement

Is the service responsive?

Our findings

People could raise any concerns or complaints with staff or the registered manager. However, they felt these were not always dealt with. A person told us, "I haven't made a complaint. I have raised the issue of time-keeping though and the need for a rota each week. They are not very good through. They promise things. I don't hear anything else." Another person said, "I am frustrated at the lack of response. It has been a bit better since I complained. They give you the wrong information. I have rang up when the staff have not arrived and am told they are almost here. When they finally got here I found out they had come from Birmingham."

Relatives felt their concerns had not been addressed. One relative told us, "Four months ago we raised an issue about a carer. [Person] does not even want them in the house. They still continue to send them. It causes [person] so much distress. I begged them not to send [staff]. I think we are being punished for saying we don't want them. At New Year no-one had showed by 6pm. We were told it was because we will not have [staff] and the call was being cancelled. I cannot get [person] out of bed alone and wanted them out of bed for part of the day. The way they don't deal with issues is absolutely appalling." Another relative said, "Nothing changes no matter how we try to address the issues with [provider]. It is not better than before."

The provider had a complaints policy which was given to people when they started to use the service. This included timescales for complaints resolutions. Complaints had been recorded in the office with details of investigations, actions taken and outcomes. These had been dealt with in line with the provider's policy. However, the concerns which were raised with us including where people told us they had contacted the provider on more than one occasion were not identified as complaints, recorded as such or dealt with in an appropriate or timely manner.

The provider failed to investigate or take appropriate action in response to complaints raised by people. These matters constituted a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Receiving and acting on complaints.

People and their relatives were involved in the assessment and planning of their care through review meetings. One person told us, "My care plan is reviewed. They came out and go through it all. This was last done about a month ago." Another person said, "We go through it with [registered manager]. They said if there was anything I wasn't happy with it could be changed." However, relatives felt they had been involved in reviews but things had not changed following these. A relative said, "Information about [person] wanting a shower is not written in our copy. It is in the one in the office. They reviewed it and we went over everything. I stated the importance of timekeeping and knowing who is coming. Nothing changed. They don't take any notice." Another relative told us, "They come out and talk to me about it. They did not include me in the last review although I am very involved in [person's] care. It was worse than the one before."

Some people were involved in their care planning; they provided information about their likes and dislikes. One person told us, "They asked me if I preferred a male or female carer. I am happy with the member of staff I have." Another person said, "They asked me directly what I preferred to be called, or if I wanted them

to wear a uniform." However, one person told us, "I have not been asked about my likes or dislikes. I will tell them if I don't like something." People did not always receive care that met their preferences. Some people preferred to receive their care at a specified time of day. For example one person preferred to have a call at 7:30am in the morning. The daily notes showed they rarely received their care at this time. Staff had not been deployed to ensure that these preferences had been met even after this had been raised by the person's family.

The provider had failed to ensure the care people received was appropriate, met their needs and was based on their preferences. These matters constituted a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person Centred Care.

The registered manager completed people's initial assessment by visiting people in their homes. One person told us, "[Registered manager] discussed it all with me." A relative said, "I was at the assessment but let [person] answer the questions as this was what they wanted to do." Care plans and risk assessments had been developed from the assessment to ensure staff had the information they required to provide care that met all of people's needs and mitigate known risks. This included specific guidance for staff on support a person who lived with diabetes. There was a care plan to give staff instructions on what actions to take if the person's blood sugar was too high. The care plans were detailed on how people wanted their care to be provided including how people wanted the staff to enter their property and let them know they were there.

People were encouraged to do things for themselves if they could. One person commented, "[Staff] is very good at encouraging me to do as much as I can." Another person said, "When I am having a shower I do as much as I can reach. They don't interfere." This was important to enable people to maintain their independence and retain skills they already had.

One person was supported with activities and going out. They told us they were supported to follow their interests and choose what they wanted to do. They said, "We plan the week together. [Staff] encourages me to make sure I get enough rest as well. Sometimes I plan too much."

The provider had information available in different formats in case people needed this; for example in larger print. This made sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

Requires Improvement

Is the service well-led?

Our findings

There were no effective systems and processes in place to assess, monitor and improve the service. The registered manager had completed monthly audits of the daily records when they were returned to the office by staff. However, the records were not returned on a regular basis and the audits did not include reviewing the times staff arrived and if all visits had been documented or completed. A quality monitoring audit undertaken by the local authority in Oct 2017 had identified daily notes were not returned to the office regularly. No action had been taken to address this.

The most recent notes available in the office at the time of our inspection were from August 2017 for some people. As people were still receiving a service daily notes should have been available up until the end of November 2017. The daily notes showed not all visits had been recorded by staff. If this had been identified measures could have been put in place to reduce the likelihood of this happening. The times when staff arrived and left had also not been audited. These showed staff arriving at significantly different times on occasions to the planned calls. They also showed staff had not stayed the full duration of the call. These concerns were not identified through the processes in place.

The audits completed by the registered manager also failed to identify staff were not recording the food people had eaten where this had been deemed necessary to monitor their eating and drinking. The records clearly showed very limited times when the actual food eaten had been recorded. This means people were put at risk of not receiving the food and drink they needed to maintain their health.

The registered manager and provider had not implemented systems to monitor if people were receiving their visits at the planned times and for the correct length of time. People consistently provided feedback through telephone interviews from January 2017 saying staff were often late. On 24 January 2017 one person told the provider 'the timing is very bad at weekends and we are not informed'. The feedback from people was similar throughout the telephone monitoring completed in 2017.

Minutes from a senior staff meeting in March 2017 identified staff were not logging in and out of the call monitoring system, were not staying long enough and were turning up early or late for visits. In April 2017 staff were given feedback at a team meeting there were concerns about reliability and timekeeping. The operations director had asked for all clients to have the call monitoring system in place. This was not actioned as the registered manager advised most people did not want this system. Consideration had not been given to an alternative system which people would be happy to use. The provider and the registered manager failed to implement systems to ensure people were receiving a service that they were commissioned to provide both from the local authority and people who funded care themselves.

The registered manager had poor insight into the impact of the lack of consistent staffing and people not receiving their care. There was a system in place which was used by the care co-ordinator to plan the rotas. However, the registered manager failed to ensure that the planned rota was delivered. Staff were allocated five minutes travel time between calls. They told us this was not enough time and reviewing journey times some routes took a minimum of 18 minutes. This time was not included in the rota meaning staff would be

late based on the planned rota. Staff also told us they were moved from their planned rota to cover for sickness or were asked to pick up additional visits. These changes impacted on people's visits and their preferences for staff. Staff told us following our inspection the operations director had implemented different rotas with less visits on so staff could realistically arrive on time. However, they also told us people had received very late calls over the weekend due to sickness.

The registered manager had not provided effective supervision to correct poor practice where this had been identified. A number of people we spoke with raised concerns about staff which they told us had been raised with the registered manager or staff at the office. The registered manager had observed this member of staff's practice and had not identified any concerns. They had also held a supervisions meeting with the staff member and not raised any concerns which had been brought to their attention. Staff told us they had also raised concerns about staff practice which had not been addressed. The registered manager failed to take further action when staff continued with poor practice. The provider did not have sufficient oversight of the registered manager to identify that the registered manager had been ineffective in assessing, monitoring and improving the quality of the care provided.

The provider and registered manager did not follow the complaints process in place. People we spoke with told us they had raised concerns about staff timekeeping, falsifying of records and staff practice. None of these concerns were recorded and investigations had not been undertaken to ensure actions could be put in place to address the concerns if these had been upheld.

People had been asked for their feedback through telephone surveys. They told us these had taken place. A relative told us, "We get them once in a blue moon. They are a waste of time. The questions are too general. I am not sure what use they are. It is a waste of time. Nothing changes." The feedback was not used to drive improvements in how the service was delivered in a timely manner. Feedback from January 2017 identified the same concerns we found as part of our inspection. The feedback raised the same areas consistently. One relative commented, "It is a waste of time giving them comments. Four months ago I raised issues, held a meeting, nothing changed. I didn't hear anything further." It was not until the operations director reviewed feedback from November 2017 where people were very unhappy with the service that action was identified as being necessary. Following this feedback a compliance manager was appointed in January 2018 and the operations director began to review the service delivery. There was no action plan in place to address the concerns until we completed our inspection and provided the feedback we had received. The provider and registered manager had failed to follow the processes in place to act on the feedback and improve the service to people.

There were ineffective systems and processes in place to assess, monitor and improve the service. This is a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The provider had failed to submit statutory notifications in relation to incidents that they have a duty to report to CQC by law. For example, allegations of abuse. People told us they had a number of times when staff did not attend their visit. Records confirmed staff had not attended all visits. Staff were also often late for visits. As missed and late calls and associated missed care is potentially neglectful these should have been notified to CQC as potential abuse. These notifications are an important safeguard for people using the service. Failure to notify CQC denies people an important level of oversight and protection.

This constituted a breach of the Care Quality Commission (Registration) Regulations 2009: Regulation 18: notification of other incidents.

People told us they were not happy with the service they received. One person said, "I would not recommend them. It is a lot of me having to call them and chasing; or they ring and say they are not coming." However, one person said, "I am completely satisfied with the carers. I would recommend them for that." Relatives told us they were not happy with the service. One commented, "The carers not showing up and being so late means [person] is suffering. We want to change to someone else." Another relative said, "The calls are abysmal. The office don't listen and don't act on anything you say. They calls are hit and miss."

People told us they were not kept informed about changes in the service or with their care. They felt the communication with the office was poor. One person said, "They are very poor at communication." Another person commented, "A newsletter would be helpful to keep us informed." One person told us, "I am told if anything changes. I had a long conversation about how things are going." Relatives felt they were not involved in changes. One said, "The communication is very poor. They don't listen and don't act. We find things out through the carers – they tell us if things have changed." The registered manager told us they met with people to review their care and seek their feedback, although they had not managed to meet with everyone yet and this was an on-going process.

The registered manager told us they were working with the local authority quality team to improve the service delivery. They had implemented systems and processes, and developed care plans to be more focussed on the person and to offer clear guidance as a result of this support.

There was a registered manager who had been registered with the service since 9 October 2017; although they had managed the location under a previous registration so had been in post for over a year. They were supported by the operations director. There were a team of staff who worked in the office to support the service. These included a care-co-ordinator and senior care staff. The operations director has appointed a compliance manager in January 2018 to review the service and identify ways to improve service delivery.

The service had up to date operational policies and procedures in place which covered all aspects of service delivery including safeguarding, medication, whistleblowing, recruitment, complaints and equality and diversity. Those which were relevant to staff were also contained within the staff handbook that was issued to all employees.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation (18) (1) (2) (e) The provider did not notify the Commission of incidents of allegations of abuse which occurred whilst services were being provided.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 (1) (a) (b) (c) The provider did not ensure the care and treatment of people was appropriate, met their needs and reflected their personal preferences.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 (1) People were not treated with dignity and respect. They were neglected and left in undignified situations.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Regulation 16 (1) (2)

The provider did not acknowledge all complaints received. They did not take appropriate action to respond to failures identified by the complainant.

Systems in place were not effective in making sure all complaints were investigated without delay. Trends and areas of risk were not identified by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (2) (a) The provider had failed to ensure staff received appropriate training to enable them to carry out the duties they are employed to perform..

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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (b) The provider did not provide care and treatment in a safe way. They did not do all that is reasonably practicable to mitigate risks. Incidents that affected the health, safety and welfare of people were not reported internally or externally. they were not reviewed or thoroughly investigated. Action was not taken to remedy the situation.

The enforcement action we took:

We asked the provider to submit an action plan telling us what actions they would take to ensure they met the regulation.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (1) (2) The provider did not protect people from abuse and improper treatment. Complaints were not used to identify potential abuse and preventative actions were not taken where appropriate.

The enforcement action we took:

We asked the provider to submit an action plan telling us what actions they would take to meet the regulation.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b)

	The provider did not have systems and processes in place which were operated effectively to assess and monitor the service. The systems and processes did not enable the provider to identify where quality and safety were being compromised. Information was not properly analysed or reviewed. The provider had sought views from people using the service. They had not taken action to address issues where these were raised. The provider did not identify risks to the health, safety and welfare of people using the service. Processes were not used to minimise the likelihood of risks or this minimise the impact of risks on people using the service.

The enforcement action we took:

We asked the provider to submit an action plan telling us how they would meet the regulation.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) The provider failed to ensure there were staff deployed to meet people's needs.

The enforcement action we took:

We asked the provider to submit an action plan to tell us how they would meet the regulation.