Westminster Homecare Limited

Westminster Homecare Limited (Chelmsford)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

Westminster Homecare Limited (Chelmsford) provides support to people in their own homes. It does not provide nursing care. At the time of our inspection the service was supporting approximately 236 people.

A registered manager was in post at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are "registered persons". Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had been absent for over 28 days on the day of our inspection. The service was being run by two area managers with the assistance of senior staff from the service, and from a neighbouring branch of the service.

We last inspected this service on 18 and 19 July 2016 where we found that the service was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was in breach of four regulations, relating to person-centred care, safe care and treatment, staffing and good governance. At our previous inspection we had found there were not enough staff to meet people's needs in a timely way and people did not consistently receive safe care in line with their preferences. The manager had not adequately carried out necessary checks to ensure that the service met people's needs. Following the inspection in July 2016, the service sent us a plan to tell us about the actions they were going to take to meet the above regulations.

At this inspection in 21 and 22 February 2016, we found four continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to person-centred care, safe care and treatment and good governance. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

At this inspection we found there had been some improvements since our last visit. There had been a focus on staff recruitment so there were more staff available to meet people's needs. Training had been improved and staff were being enabled to develop their skills, particularly in the area of dementia care.

As we had found at our last visit, where people had established staff, they received care which was of consistently good quality. However, poor coordination combined with inadequate care plans meant risk was not well managed and staff did not have sufficient information to manage people's needs safely and in a person centred manner. Unsatisfactory oversight by the manager meant they had not fully addressed on-going concerns.

Poor scheduling of staff rotas meant that some visits were missed and people did not receive the support their required. There were not effective systems to monitor missed visits and the impact on people. Risk assessments were out of date or inaccurate and did not provide staff with the necessary information to reduce risk.

Whilst improved processes for the administration of medicine were being introduced these were not fully established and staff did not have sufficient information about the support people needed with their medicines.

There had been a positive focus on improved training for all staff and this was leading to improvements in overall skills. However, where people had specific needs, staff did not always have access to specialist training and information.

The CQC is required to monitor the Mental Capacity Act (MCA) 2005 and report on what we find. The service had started improve measures in relation to assessing people who may lack capacity but this was still at an early stage. Staff offered people choice and had a working understanding of supporting people who lacked capacity, however they did not have adequate information in relation to people's needs in these instances.

Where staff knew people well they supported them positively to maintain good health and wellbeing and access resources as necessary. However, lack of information about how people's health conditions affected them meant staff did not have enough guidance on how to best meet their needs.

Some people were supported by staff who were caring and knew them well. They became anxious if these staff were not there as replacement staff did not always know about their needs and preferences. Measures to improve care plans were not functioning well and when people's needs changed their care plans were not revised. As a result, staff, people and their families were often confused about the level of care being provided.

When people complained they received a response from the manager and improvements were made to the service. However, there were limited efforts made to gather to feedback about people's individual circumstances and so opportunities for understanding peoples experience of care were lost.

A number of new staff had been appointed to resolve concerns we had raised at our last inspection and measures to check on the quality of the service had been put in place but these were not yet operating effectively and any improvements were not yet shown to be sustainable. Communication between the registered manager and the provider had not been open and effective and as a result concerns had not been dealt with in a timely manner. When the provider became aware of concerns at the service they were pro-active about putting things right.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff did not always have enough information about how to manage risk when supporting people.

There were sufficient staff but coordination of visits did not always function effectively and the risk of missed visits was not minimised.

Staff had the skills to administer medicines safely; however they lacked the necessary information about the support people needed with their medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

Training was in place to develop staff skills to meet people's needs; however staff needed more support to develop specialist skills.

Staff worked within the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and knew how to support people to make their own choices. Care plans did not provide clear guidance in relation to people's capacity.

Staff supported people to maintain good health and wellbeing and to have access to adequate nutrition. Information regarding people's specific needs was not readily available.

Is the service caring?

Requires Improvement

The service was not always caring.

People were anxious when they were not supported by their usual carer.

Care plans were not always written in a caring manner.

Where staff developed stable relationships with people, they

treated them with kindness and knew them well

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive a continuity of care due to poor coordination of rotas and care plans which did not fully outline their needs and preferences.

People's needs were not reviewed to ensure the service they received was in line with their current needs and preferences.

Whilst formal complaints were responded to well, people were not encouraged to provide feedback about the service they received.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The communication between the registered manager and provider was not open and robust so concerns were not dealt with in a timely manner.

There were a number of systems in place to measure quality but these did not consistently lead to improvement in the service.

The manager had started to put measures in place to address the concerns raised at the previous inspection; however these had not yet resulted in improvements in the service.

Westminster Homecare Limited (Chelmsford)

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.

The inspection took place on 21 and 22 February 2017and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that the right representatives from the organisation would be available to respond to our queries.

The inspection team consisted of two inspectors and one expert by experience, who carried out phone calls after the visit to the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

On the day of the inspection we visited the agency's office and spoke with two area managers, the manager of another branch of the organisation, the deputy manager, plus other office staff. We spoke to the trainer and recruitment officer plus eight carers or care coordinators. We visited five people who used the service and their families. We met the staff supporting people at the visits. We spoke on the phone to twelve people and five family members. We spoke to two health and social care professionals to gather their views on the service.

We reviewed all the information we had available about the service including notifications sent to us by the manager. Notifications are information about important events which the provider is required to send us by law. We also looked at information sent to us from others, including family members and the local authority.

We looked at nineteen people's care records and four staff records. We examined information relating to the

management of the service such as health and safety records, personnel and recruitment records, quality monitoring audits and information about complaints.

Requires Improvement

Is the service safe?

Our findings

When we last inspected the service we found people were not always safe as staff did not have adequate information about their individual needs before they started providing care. At this inspection staff still lacked adequate guidance to minimise risk and meet people's needs safely. People who were being supported by their established staff member were being supported safely and we received positive feedback about the quality of this element of the service. We were not assured however that people were safe when they were being supported by replacement or new staff.

We were concerned that new people had been accepted into the service before our concerns regarding existing care plans had been addressed. We were advised however that a suspension had been put in place immediately prior to our recent inspection as the area manager had become increasingly aware of issues at the service.

We previously found there were insufficient staff to meet people's needs safely. There had been a focus on staff recruitment and we saw some improvement in this area; though the scheduling and coordination of staff remained of concern and resulted in a number of missed or curtailed calls. We were particularly concerned of the impact on people who were unable to tell someone there had been a missed visit, for example, due to memory loss.

There was a failure to log and investigate missed visits adequately. The registered manager had reported on very few missed visits in 2016. Changes in the management prior to our inspection had led to improvements in the logging of the missed visits, and as a result concerns had started to be addressed more fully.

There were 12 missed calls between 6 and 20 February 2017. Initial investigations indicated missed calls mainly resulted from a breakdown of communication between care coordinators and care staff. The temporary manager had started addressing these communication issues and had sent letters of apology to people affected by missed visits. Investigations did not however, highlight clearly what the impact of the missed call was and the level of risk should this re-occur, for example where people needed support with time critical medicines.

When we spoke to people affected by missed visits they were often unable to tell us what the impact was, for example, if they had memory difficulties. On other occasions, the impact was clearer. One family member had complained to the service that when their relative's usual staff member was away, replacement staff did not complete required tasks. On one occasion their relative was left without water and a plate of food was put out of reach and not covered in cling film, as required. A lack of care plan meant there was no guidance for family members or replacement staff to refer to. The registered manager had responded to the complaint explaining that the replacement staff had shadowed the usual staff. The manager had also met with the staff involved to address the concerns raised. They had not however ensured a care plan was then put into place.

Missed visits were recorded when people or their families alerted the office or where there was a discrepancy

between staff rotas and invoices. There were no examples on the missed visits log where gaps had been highlighted by a senior member of staff checking daily records or from unannounced spot checks. As a result, it was not clear how the manager would be aware that there had been a missed visit for people who had memory loss and lacked a representative raise concerns.

During one of our visits we observed a person with dementia was reluctant to accept care but through a mixture of humour and patience their regular staff member encouraged them to accept support with personal care. We saw in their daily notes that there were gaps in the recording of visits when their regular staff was absent.

We raised this with the deputy manager who advised that the person had refused a visit by phone. This demonstrated a lack of understanding of the person's needs in relation to their dementia and did not follow the best practice shown by the usual carer. This also failed to follow the guidance issued to staff which stated, "If a client has dementia and declines any form of care on the visit, this can be due to their condition, you must deliver the care which is required to meet their needs. Rather than let a client decline any form of care use prompts and gentle persuasion, if a service user keeps declining care please make your coordinator aware of this."

We discussed scheduling of visits with a care coordinator who showed us how they managed staff availability. We looked at the scheduling for one member of staff and noted there was insufficient travel time planned between visits. The care coordinator said, "Some (people) don't take the full time and if there is nothing else to do then staff will leave." They agreed that on the morning we were looking at the member of staff would have to either run late or cut planned visits short. Alternatively we were told some staff might start early to fit all the calls in. Staff confirmed with us that when calls were slotted in they were often late to visits and ended up working longer hours than scheduled.

We discussed this with the area manager who told us the system flagged up where visit times were scheduled incorrectly but the scheduler could override this, as had happened in the above example. We were told this was an unacceptable practice, except in exceptional circumstances.

There was an on-call system for out of hour's emergencies. This was jointly staffed with senior staff from a neighbouring branch. These staff did not know people in this service well and the lack of care plans meant they were not able to make informed decisions about how people's needs should be met, for example, if their usual staff went off sick. A member of staff told us they had to alert a care coordinator that a person was on warfarin and of the risks of a late or missed visit, as this was not in their care plan. A member of staff said, "The on-call person is usually from Colchester, so does not know clients or us, it is not helpful."

There were processes in place to assess risk such as manual handling and environmental. Where there were incorrect or missing care plans we found potential for risk had not been minimised. Lack of guidance for one person meant advice was missing which had been provided by the referring professional and stated "Supervision is required when mobilising due to risk of falls." An audit of this person's care notes was carried out by the manager on 20 December 2016, when the missing care plan was highlighted but on the day of our inspection there was still no care plan. This had placed this person at an unnecessary risk of falling.

For another person, their care plan stated the person could walk, however they now required support with a hoist but there was no guidance available for staff. We were told the person's needs had changed six months prior to our inspection but the care plan had not been amended.

Where people had families, they were often used to train new staff, which was not appropriate or safe. A

family member said, "My regular carers are excellent but any new ones that arrive do not know what to do, I say to them 'What has the office told you about my husband and they usually say nothing. I have to teach new carers what to do."

At our last inspection we had raised concerns regarding the administration of medicines. We were shown a new system for recording of medicine administration which was due to be introduced once all staff had received training. This new system and revised medicine administration record sheets (MARS) addressed many of the concerns we had raised.

However, whilst we were assured these changes would make the administration of medicine safer there was not always sufficient guidance in place for staff about what medicines people took and what support they needed. For example, a person who had been receiving care since October 2016 did not have a care plan in place, despite being prescribed a time sensitive medicine. The manager had failed to prioritise this care plan or to put temporary information in place for staff.

Another person's daily notes showed no support was needed with medicines but their care plan stated, "Care workers to assist me with my medication. Carers to put tablets in a medicine pot and observe me taking them a couple at a time with water." A third person received support with putting a pain patch on and medicated cream, despite their care plan stating they were independent with medicines. We shared our concerns with the provider to ensure they put measures in place to resolve these inconsistencies.

A person told us, "They don't even know about my tablets. It really upsets me, this sort of thing."

People told us they felt less safe because when replacement staff visited they did not always have ID badges. A person told us, "They don't all wear name badges and we get a lot of different people." A member of staff told us, "We have never had an ID badge and keep asking for them."

The registered manager and provider had failed to adequately assess the risks to the health and safety of service users and had not consistently put in place measures to mitigate risk. They had also failed to ensure the proper and safe management of medicines. These failings are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Robust recruitment processes were in place for the safe employment of staff. Checks of the recruitment files evidenced completed application forms, proof of identity and satisfactory references were obtained. The provider had also undertaken a Disclosure and Barring Service (DBS) check on all staff before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

We met with the new member of staff was responsible for recruitment and noted the system in place was ordered and functioned well. Staff agreed that whilst they were still busy there were now more staff. A member of staff told us, "We have recruited more staff recently so it's slightly better."

Despite our concerns, many people were positive about how safe they felt with staff. People said, "Carers always turn up; never had a missed call and they do let me know if they are going to be late", "We feel very safe when the carers are here" and "They always stay the right amount of time, I make sure of it."

Staff we spoke with had completed training about how to support people safely and recognise the signs of and how to report abuse. They knew the actions to take, such as reporting issues to their manager and other agencies, including the local authority safeguarding team. Staff told us about the whistle blowing process

and said they would not hesitate to report other staff if they had concerns. One staff member told us, "I would speak to the deputy manager or Manager and any relevant social worker, and this would be raised as a safeguarding. Another said, "I would ring the office straight away." The manager logged and investigated safeguards.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found staff did not have the necessary skills to support people with dementia. Whilst we found there had been progress in this area further improvements were still needed to ensure staff had the specific skills to support the people they visited.

Feedback from people about staff skills was generally positive. One relative told us, "They know what they are doing, and if we ask for anything it is done. The previous company I had we were always finding bruising but these know how to move [family member] safely." A person said, "They've been very good. They seem well enough trained. We have a young girl starting. They called two at a time so she had help and was with a trained member of staff. I think I'd go elsewhere if it was not good enough."

Since our last inspection a new trainer was now in place who worked at the service two weeks each month. They told us they had mainly been responsible for carrying out refresher training with staff, in response to the findings of that inspection. As a result most staff had now completed a number of refresher courses which included a dementia course. The trainer told us they were receiving feedback that the new training was more detailed and in-depth. Staff confirmed this and said, "The recent training is much better", "we have practical training on hoists, slings and equipment" and "the training does equip me for the job."

Where there were gaps in staff knowledge this was either due to poor scheduling where staff without the necessary skills were sent to support a person or where staff had not been trained to meet complex needs. A person told us, "Most are well enough trained generally but not around the specifics like not trained about my specific needs."

The trainer told us, "Manual handling includes practical training with hoist, recliner bed, slide sheets, slings, and rotunda. Any new equipment myself or field carers will go out and meet with occupational therapist and then cascade training." They told us new carers would not be sent to a property with equipment unless they had been shown first or working with more experienced double up partner. However, in practice this did not always happen. A member of staff told us, "We have a stand aid hoist for [Person] but have never been taught how to use it." A person described how "The O.T. (occupational therapist) instructed carers how to use the equipment to help me stand up safely. I have so many different carers call it's hard for me to know who can and who cannot use it and some cannot do it right anyway."

New staff received induction training over five days, covering a number of issues such as medicines, moving and handling and food hygiene. Staff were observed throughout the week and tested at the end of each topic. A member of staff told us "I had a five to six day induction and we receive refresher training every year, colleagues have told me the new trainer is excellent."

At our last inspection we had concerns that staff did not have the necessary skills to support people with dementia. As well as additional training, we saw in records from meetings and newsletters that advice had been given in this area. The trainer was able to describe in detail good practice in the area of dementia, but were not aware that care plans did not reflect or provide guidance in line with the training being provided.

When people had dementia they were therefore not assured of a consistently good service. We observed a member of staff expertly encouraging a reluctant person with memory loss to have a bath. The member of staff was also skilled at supporting the person with eating and taking their medicines, enabling them to remain independent. When we looked at the person's care plan however, there was no reference to the support needed to manage dementia, so a replacement carer may not have known how best to meet the person's needs.

Staff told us about the impact of the lack of guidance in care plans. An established member of staff told me they had been contacted by a new carer who could not find where medication was stored as this was not recorded in a person's care plan. They told us, "I've told the care coordinator loads of times the care plan needs updating and nothing happens." They also told us, "You get told nothing and when you walk in it's a real surprise. You would not know they have dementia or anxiety."

Feedback from staff was mixed in relation to the support they received. This was largely based on the geographical area they worked in, and whether they were well coordinated. One member of staff told us, "We have not had a care co-ordinator for a long time so communication is not great." Some staff were negative and felt they were put under pressure to take on extra work, which affected the people they supported. Other staff were more positive, for example, they told us, "I love it. I did try another company, not for me. They don't pressure you, always there, they back you up" and "On the whole they listen, we needed a slide sheet, spoke to the office and it was there the next day."

Records showed staff received regular supervision and annual appraisals. The appraisals documents we looked at were detailed and challenged staff to improve their practice. There were examples where staff had been supervised when there were concerns about their practice. Feedback from staff was mixed when we asked whether they were well supervised. Staff told us, "We have supervision and spot checks", "I have supervision every 6 months but there is always on-going advice" and "We used to have supervision but not had one since summer last year."

Whilst spot checks were not used effectively to highlight missed visits, we saw they had been used more positively to observe staff practice. For example, one spot check had resulted in increased monitoring of a member of staff. However, this was not done consistently across the service. One member of staff told us, "No one has spot checked me in three years."

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. Since our last inspection the manager had discussed the MCA with staff and highlighted their responsibilities in this area. We were told that the service was starting to carry out more assessments of people's capacity under the MCA, though we did not see this in any of the files we looked at. The information and guidance in people's care plans was minimal in relation to their capacity though there was guidance to staff to support people to make their own choices, for example about what to have to eat or wear. Staff put this guidance into practice. One member of staff told us, "We offer a choice of food; one lady loves a bacon sandwich for breakfast."

We spoke with staff to assess their working knowledge of the MCA. Staff we spoke with were aware of the need to consider capacity and what to do when people lacked capacity. Staff told us, "I always ask and when dressing will show different garments so people can choose" and "We look for consent in the care plan and talk to the family, GP or social worker."

We looked at whether people were being supported to eat and drink sufficiently and found that where people had established staff this support was being provided effectively. At our last inspection we were concerned about lack of support being provided to people with dementia with their eating and drinking. Concerns remained about the impact of missed visits, especially when people needed reminding to eat due to memory problems.

However, there were also improvements and evidence that the manager had started to address this concern. Good practice was shared with staff in their newsletter, which stated, "A carer who has used techniques learnt in refresher training to promote a service user with dementia to eat better. The carer had implemented the technique of placing food on a brightly coloured plate and removing a patterned table cloth, and replacing with a white table cloth. This is fantastic news for the wellbeing of the service user, and for the family giving them peace of mind. If you feel any service users would benefit from this technique, please contact [trainer]."

We saw some good practice during one of our visits we observed a member of staff offered a person a drink four times and in different ways, including fortified drinks. They suggested the person dunked biscuits as a way of motivating them to eat and drink more. We noted they were skilled at ensuring the person had enough fluids while still offering them choice.

Where relevant, staff worked together with health and social care professionals and families to promote people's good health and wellbeing. Some care plans documented people's health needs and contact with other professionals, whilst others were less detailed. For example, one person's health condition was listed but there was inadequate guidance to the member of staff about how this affected them. There had been a focus on training staff to bring their skills and knowledge up to a general level. Inadequate assessments and scheduling did not always highlight people's complex health needs so staff were not deployed or trained effectively to meet more specific needs.

Despite these concerns, many staff we spoke to were experienced and they had developed knowledge about the health conditions people experienced. They had good working relationships with other local health staff. A family member told us, "The carer alerts us to get the doctor and found out about things as well for us."

Requires Improvement

Is the service caring?

Our findings

When we spoke with people about the care they received at our last inspection they were positive about their regular staff but more negative about any replacement staff who supported them. We found this had slightly improved at this inspection but remained a concern. One person told us, "I get a very good carer but when she is off its hit and miss. On Sunday they never came at all and let me down. And I could not even get a shower, before we had an appointment." Other people said, "If the carer is changed then it all goes awry. It falls down if the regular is not here" and "It's not bad but I'm having to often explain everything when they call here."

Family members and people were anxious about what would happen if usual carers went off, often choosing to cope without care during this period. One person told us, "I've a good regular but she is moving away so I'm worried." This level of anxiety demonstrated measures were not in place to enable staff to provide a caring service to people when there were cover arrangements in place. In particular, the failure to update and put in place care plans meant people's preferences and needs were not clear to replacement staff.

Care plans were not always written with respect and did not provide sufficient guidance to enable staff to communicate well with people. For example, a care plan for one person stated they could not hear clearly. The guidance in the section called "communication" was for staff to "speak loud." Subsequent information indicated the person could lip read but staff were not given any guidance, for example, on the need to face the person.

Although care plans were long they were not written with warmth and did not let staff know about those small things which would improve people's quality of life. For example, when we visited a person with dementia, a member of staff told us they liked to eat their lunch at 1pm with the news, but this was not written in the care plan. Another care plan did not refer to the importance of keeping in contact with a family member, even though this was an important relationship which staff needed to be aware of.

Lack of checks on staff meant uncaring practice was not always picked up. We read some daily notes which were warm, informative and detailed. However some notes were written disrespectfully and focused on tasks. For instance, one set of notes said, "[Person] has messed over the carpet so I had to scrub it. Meds, no food, water." Any person or family member reading the notes would not be reassured they were being supported by a caring member of staff.

Observations of staff interacting with people showed that people were treated with dignity and respect. One relative said, "They always cover [person] when they transfer them. "Staff we spoke with had a good knowledge of the importance of treating people with dignity. One staff member said, "I shut curtains and use towels to cover." "We talk to [person] while we are washing them as they are not keen but this distracts them, we also use music."

People were overwhelmingly positive about how warm and caring their usual staff were. One relative said,

"The carer is absolutely fabulous and does him so much good. They have a laugh." Regular staff had a good understanding of people's interests, likes and dislikes. This meant that staff could have conversations with people about things that were important and of interest to them. A family member told us, "Carers talk to [family member] as they are helping them, and one of the carers always plays music for [family member] as they love music. They laugh and dance with them."

Despite our concerns over scheduling, where usual rotas were in place, people told us staff stayed for the agreed time. Support was unrushed and personalised. A staff member told us, "If [Person] doesn't need anything I sit and have a chat (for the rest of the allocated time)." Staff were patient and encouraged people to do as much for them self as possible. One staff member told us, "I am there to assist, not do."

Whilst there was limited guidance in care plans on how best to communicate with people, staff took time to get to know the people they supported. One staff member told us when talking about a person with no verbal communication, "I use body language and facial expressions as you can see immediately what mood they are in. We take our time and talk to them the whole time."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found the care people received did not always meet their needs and reflect their preferences. At this visit we found that whilst there had been some improvements, poor scheduling and inconsistent care plans meant that when people were not being supported by their usual staff the care they received was not adequate. In addition we found that the measures put in place by the manager had failed to address many of the concerns we raised at our last inspection.

A person described their frustration at not knowing what support they should receive, 'They were telling me at the office that we did not get care on a Sunday when we do. They did not seem to know the care package. I do not seem to have a care plan with the details in it. I haven't really got anything in writing apart from a log but then when someone else came round they did not know the details. I thought the visit was 45 minutes but they say its 30 minutes. It's a muddle."

Most people had a care plan in place for the care and support they needed, however a number of care plans were out of date or inaccurate. For example, one person's care plan stated they needed support washing and dressing but did not mention support with showering. The plan did not mention the person needed a tea time visit, though this was being provided by the service. There was no guidance on the support needed with eating, drinking and taking medicines due to memory loss. We visited the person during our inspection and found the member of staff supported them in a personalised manner, meeting their complex needs effectively. We were not assured that the person's needs would be met when that member of staff was absent.

Some care plans lacked the detail needed to provide personalised care and support to people. This meant that when a person could not communicate their needs, replacement staff did not know how to provide care in their preferred way. During one of our visits the member of staff explained the importance of sitting in silence whilst the person ate their meal and had their medicines. When we looked on their care plan, this advice was not there. We found another person received assistance with catheter care; however, there was no guidance in the person's care plan about this. A third person was said to have challenging behaviour and be verbally abusive but no guidance was found in the care plan for staff supporting this person.

We also found that people's care records were not always updated when their needs changed or when they had requested specific changes. For example, one person's needs had changed in relation to mobility, which meant they needed support to move with a hoist, but the care plan still stated they were able to walk. A family member told us, "They did not assess on his coming out of hospital. I don't recall any assessment then and no care plan was set up."

We found two people did not have care plans in place. However daily notes confirmed the service have been providing personal care to one of the people since August 2016. An audit took place in December 2016 and highlighted there was no care plan in place but it was not clear what, if any action was taken to resolve this. Care notes for this person indicated the care being provided, which included assistance with taking medication. There were gaps in the daily notes when there was no record of a visit, however a lack of care

plan meant it was difficult for us to measure what tasks had been missed. We gave the details of the two people without care plans to the deputy manager for them to address our concerns.

Some families told us that although they could survive when things went wrong, this caused them unnecessary frustration. For example, one relative told us the office rang to say they could not make a morning visit before midday, so the family arranged for a neighbour to pop in. We were told, "[Person] would be able to manage but struggle and wouldn't be able to put their cream on." Another person told us staff rung to say they could only make the evening call at 10pm so they refused the call as it was too late and did not have a shower that night.

Staff told us people were not able to make a preference for a female member of staff. One of the care coordinators advised they aimed to accommodate preferences of gender and before people received the service they should have been made aware by the referrer that they may need to accept male carers. However, lack of communication meant people were not always aware and could therefore be dissatisfied.

The manager had appointed a member of staff to carry out reviews of people's care and ensure up-to-date care plans were in place. However, this task had not been done adequately and the manager had failed to resolve this effectively. Immediately prior to our inspection the provider had become aware that there were gaps in the care plans and had started to address this issue. However at the time of our visit, there were still a number of people without care plans or whose care plans were out of date or incorrect.

Staff did not have enough guidance to meet people's needs and preferences. This was a breach of Regulation 9(1)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us they received good quality care and had no concerns. At one of our visits, a person told us the care plan outlined exactly what needed doing, and they had a good relationship with the staff, who knew they well. Another relative told us, "They are very reliable, and an odd time they ring to let us know they are late, and we don't mind. [Task] is done with dignity and they take their time to do it right and make it easy, they chat and keep [Person] involved."

People were supported by their usual staff to minimise the disruption caused by inadequate cover arrangements when rotas changed. One person explained, "[Usual carer] tries to help me on the days I go to the day centre. If she is off the times go wrong and I don't know who is calling."

There was a complaints policy and written complaints were logged. We saw that where people had complained in writing, they received a written reply which often included details of any investigation by the manager. We also saw that learning from the complaints was used to communicate with staff, for example, the manager would highlight poor practice and offer guidance in the team meetings. This demonstrated formal responses received a good response.

However, given the negative feedback we received when we spoke to people, we were not assured people's feedback was being effectively gathered and used to make improvements at the service. The lack of an effective review process meant the service was not addressing many of the issues which had been raised with us. A person told us, "The manager is not very responsive, I went above her recently to the area manager who did respond straight away. The office don't really get back to me about things. They are polite enough but they are not doing anything about things."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found the manager had failed to manage risk effectively and the quality checks in place had not addressed the concerns we found. At this inspection we found there were some improvements. For example, the training in place was more in depth, particularly in the area of dementia. The focus on recruitment was increasing the availability of care staff.

However, we found our key concerns had not been addressed and the service was still not managing risk adequately. Inaccurate care plans, poor scheduling of staff and missed visits meant we were not assured people's needs were being met in a consistent manner. The manager had not responded effectively when measures which had been put in place to deal with concerns failed to lead to improvements.

Feedback from people was mixed about the service. People were positive about their usual staff but generally negative about replacement staff and contact with the office. One relative commented, "They've been very good overall with us, our girls are lovely though I don't know what goes on with the office." Another person said, "The service is good and the carers are good, much better than last service I had."

The registered manager was absent during our inspection and we were informed of a high level of absence at the senior level of the service, as a result of sickness and other circumstances. We noted there had been a long period following our last inspection when our concerns were not being managed well. At this point the manager had been meeting with the area manager and reporting to them, but this had failed to highlight where there were issues. Immediately prior to our inspection, the service was being supported by two area managers who had put a detailed action plan in place, however it was too early for improvements to have been made.

In the period from our last inspection until the absence of the registered manager, 31 new people joined the service; despite the fact the manager had not resolved the lack of adequate care plans and assessments for existing people. The halt in accepting new people into the service had only been put into place following the absence of the registered manager a few weeks prior to our inspection visit.

Staff comments regarding the management of the service were mixed. One member of staff told us, "Things have improved slowly, there has been a lot of change but there is still room for improvement." We received feedback that the registered manager was not visible and did not come out to see what the service was like in people's homes. One relative said, "They never come out with the [staff] to see how things are and follow them, they might understand how things are." A member of staff said, "The manager does not know staff or clients; I have been here for 6 years and only seen them about 3 times." This lack of oversight meant the manager had not picked up many of the concerns we had found at our inspection, where after one visit to people in their homes it was clear the care plans in place did not correspond to the people we had met.

The registered manager and provider had failed to fully resolve the concerns we had raised at our last inspection. As a result, risk was not minimised and the service provided did not consistently meet people's needs and preferences. This was a breach of Regulation 17 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Since our last inspection a new officer had been appointed to check on the quality of the service and a new deputy manager had been joined the service. However, there had not been sufficient time to measure whether the improvements they had implemented were sustainable. Despite the new systems in place to check on the quality of the service, and there were still a number of concerns, for example there were inadequate reviews of care plans and lack of checks on daily records.

The manager communicated with staff through a newsletter called 'The Grapevine' and through team meetings. We looked at copies of the newsletter and saw they were used to raise a number of the issues of concern we found in our inspection. In particular, advice was given to staff on how best to minimise missed visits and support people with dementia. The advice was written clearly and the guidance practical and informative.

Despite the concerns we had found during our inspection, some aspects of the service were well ordered. When we spoke to staff they were clear what their role was. Immediately prior to our visit the service had moved to new offices. This move had been managed efficiently and when we visited, office staff were well settled in the new premises. We were not made aware of any disruption to the service resulting from this move.

The provider and other staff worked openly with us when we asked questions during our inspection. We saw that they were also working with other stakeholders who were involved with contractual or safeguarding alerts. There was a commitment to put things right at a structural level to resolve the issues effectively and in a sustainable way.

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 RA Regulations 2014 Person-centred care Staff did not have enough guidance to meet people's needs and preferences.

The enforcement action we took:

Notice of Decision with positive conditions

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered manager and provider had failed to adequately assess the risks to the health and safety of service users and had not consistently put in place measures to mitigate risk. They had also failed to ensure the proper and safe management of medicines.

The enforcement action we took:

Notice of Decision with positive conditions

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager and provider had failed to fully resolve the concerns we had raised at our last inspection. As a result, risk was not minimised and the service provided did not consistently meet people's needs and preferences.

The enforcement action we took:

Notice of Decision with positive conditions