Castlerock Recruitment Group Ltd

CRG Homecare Workington

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This was the first inspection of CRG Homecare Workington since registration. We spent two days in the service. The first day was 2 November 2016 and was unannounced. We arranged to return the next day and we called staff and people who used the service on 4 November 2016.

CRG Homecare Workington delivered domiciliary care to adults in the Copeland, Allerdale and Carlisle areas. The company won the tender to provide care on behalf of Cumbria County Council and started to deliver care in February 2016. The service was registered in April 2016. At the start of the week beginning 31 October 2016 203 hours of care and support were delivered in Carlisle and 808 in Allerdale and Copeland combined. There were 113 service users and 48 staff, delivering care throughout the area every day of the year.

The head of operations had been registered as the manager of the service as an interim measure until a locally based manager could register. Two previous branch manager had not registered. The service had a new branch manager who was in the process of applying to register as the manager. 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.

Suitable arrangements were in place so that staff could identify and report any safeguarding incidents. Not all matters of safeguarding had been reported to the Care Quality Commission. We made a recommendation that senior staff received further training about managing safeguarding.

Risk assessments had been done and some had been recently updated. We have made a recommendation that all risk assessments were reviewed to ensure that risks continued to be reduced.

We found a number of issues around recruitment and disciplinary matters that might have put vulnerable people at risk. This was a breach of Regulation 19 of the Health and Social Care Act 2008; Fit and Proper Persons employed because appropriate background checks were not in place for some staff. Concerns about fitness and ability to carry out duties had not been dealt with appropriately.

We judged that the service had not always been well staffed but we saw that efforts had been made to recruit enough staff. We have made a recommendation that the provider review their recruitment and retention of staff procedures.

We found that medication administration had not been done correctly in some homes. This is a breach of Regulation 12 of the Health and Social Care Act 2008: Safe and care treatment because the provider had failed to ensure the proper and safe management of medicines.

Staff had received suitable levels of initial training but their competence had not been checked in the

delivery of care and support. Supervision and observation of practice had not been completed routinely. This was a breach of Regulation 18 of the health and Social Care Act 2008; Staffing because the provider had failed to ensure that staff were competent, skilled and experience to deliver good standards of care.

We had some evidence to show that communication within the team and with other professionals had not always been good. We saw that steps were in place to improve this but we made a recommendation that this continues to be reviewed so that lines of communication continue to improve.

We saw evidence to show that people had been consulted about consent to care and that the new manager was ensuring that everyone they supported understood this. We were informed that no one was being deprived of their liberty because of any actions taken by the provider.

We saw that staff had training on nutrition and hydration and that the service did not have any complex work around this need. We recommended that the service look at more in-depth understanding of hydration and nutrition so that they could meet these needs if necessary.

Staff understood their responsibilities in supporting people to get the right kind of health care support.

The office was suitable as a base to run the service. The provider had a small satellite office in Carlisle so that staff did not have to travel to Workington.

We had responses to our surveys and telephone calls that indicated that most staff were caring. We had further evidence to show that late, shortened or missed calls had compromised the dignity of individuals. This was a breach of Regulation 10 of the Health and Social Care Act 2008;Dignity and respect because the delivery of care did not always ensure that people were treated in a caring and compassionate way.

Assessment and care planning was not up to date. The care delivery had not been analysed on a routine basis. Some houses had no care plans in place. This was a breach of Regulation 9 of the Health and Social Care Act 2008: Person centred care because the provider had failed to fully assess people's need and care planning and review were not being completed adequately so that safe care and treatment was provided.

The company had a suitable complaints procedure. The procedure had not always been followed but the registered manager and the provider were ensuring that any outstanding responses were dealt with. We have made a recommendation that the provider continues with this and contact any person where a complaint had still not been resolved.

The provider had a detail and suitable quality monitoring system but this had not been followed in the service. We saw that in the last month or two some progress had been made by the area manager and by the new branch manager. We also had evidence to show that the monitoring of quality in relation to care planning, recruitment, supervision and the deployment of staff had not been monitored closely. Quality improvements had only started to be made. Records were not well kept.

This is a breach of Regulation 17 ;Good governance because quality monitoring systems and processes had failed to assess, monitor and improve the quality and safety of the service.

We also had evidence to show that the provider had failed to notify the Care Quality commission of events in the service. This is a breach of Registration Regulation 18: Notification of other incidents. We will be taking further action separate from this inspection.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Recruitment and disciplinary matters were not completed in a robust enough way to keep people safe.

Staff turnover and staff vacancies meant that some management tasks were not being done.

Records relating to medication needed to be completed and staff competence checked.

Is the service effective?

Requires Improvement

The service was not yet Effective.

Staff received good levels of training but needed more formal supervision and observation of practice.

Nutrional planning needed to be developed.

Communication channels within the service and with other professionals were being developed.

Is the service caring?

Requires Improvement

The service was not always caring.

Most of the people we contacted thought that individual staff were caring and treated them respectfully.

Some of the late, missed and shortened calls had led to a loss of dignity for some people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Assessment and care planning needed to be updated and more details of care delivery included.

Care plans needed to be in every home so that staff had suitable guidance.

The service had a complaints procedure but some complaints still needed to be resolved

Is the service well-led?

Inadequate

The service was not well-led.

The service had a registered manager who was not in day to day charge of the service.

There were good quality monitoring systems but these were not being used as effectively as possible.

CRG Homecare Workington

Detailed findings

Background to this inspection

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

This inspection started on 2 November 2016 and was unannounced. We then returned to the office on 3 November 2016. Staff and people who used the service were contacted by telephone after this date.

The inspection was carried out by an adult social care inspector. An expert-by-experience telephoned the staff and people who used the service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses domiciliary care services.

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

We also spoke to social workers and quality managers employed by Cumbria County Council because the local authority had CRG Homecare Workington under review as part of their Quality Improvement agenda. We used minutes of these quality meetings to evidence some of the report. We had also been sent information from individual social workers.

We telephoned twelve people who used the service after our visit to the office. We also spoke to five relatives or friends. We had spoken to two service users and three relatives prior to our visit because they were unhappy with the care delivery. We also looked at minutes of safeguarding meetings and spoke to the local authority when people had made complaints. We read fifteen care files over the two days. This included assessments and care plans. We saw Medication Administration Records for people and we reviewed five log books which contained daily notes related to people's care.

The lead inspector spoke to the new branch manager, the area manager, two of the care co-ordinators and to three new staff and two existing staff. The expert by experience spoke with five staff. We had also had contact with three members of staff prior to our inspection. We looked at six recruitment files and a further six files of staff who had been in post for a few months. We also requested a training plan and a record of training. We received copies of these and we saw the records kept in the office.

We looked at the audits that had been completed as part of quality assurance. We also looked at selected policies and procedures of Castle Rock Recruitment where we needed to ensure the procedures were being followed.

Inadequate

Is the service safe?

Our findings

People told us that they felt "safe enough" with the staff but that sometimes, "When they didn't turn up or were two hours late I didn't feel very safe." People also told us that they judged that, "There's not enough staff...staff keep leaving as they aren't happy." We heard from people who were unhappy with the way they were supported with medicines. One person said, "The issue with the medicine has really worried us all...its important that [my relative] gets this and we have been let down."

On both days of the inspection when we visited the main office we met with an internal trainer who was giving new staff induction. This included safe guarding. We spoke to staff who understood how they would report any matters of safeguarding. We also noted that when supervision had been done, safeguarding matters were included. The manager was aware of her responsibilities in protecting vulnerable adults. She had ensured that staff had access to guidance related to making safeguarding referral. We also noted that, because the area manager had read every file, any concerning issues would have been identified. We noted that the management team had not always notified the Care Quality Commission about potential safeguarding matters and we discuss this under 'Well-led'.

We made a recommendation that further training be provided so that the management team feel confident and competent in dealing with any safeguarding matters that may arise.

Some care files contained very good individual risk assessments; some still needed to be updated and detailed. Staff were given training on lone working and had been given advice about how to keep themselves safe. The organisation did have an emergency plan. This plan needed to be updated to include more specific contingency plans for bad weather or local emergencies. The community nursing teams and social work teams were planning to give the service support in dealing with any issues arising. A new emergency plan was being drawn up with the help of these agencies.

We made a recommendation that risk assessment and risk management for the organisation be re-visited to help to reduce risk to service users and staff.

We looked at the arrangements in place for recruitment and we saw that the systems were of a good standard. We looked at a number of recruitment files and, despite the system in place being appropriate, we found a number of problems. We saw that not all recruits had suitable references taken up. We also noted that some staff had started to work before the checks on their background had been returned. This meant that checks on criminal records and on any dismissal from care services had not been disclosed prior to the person starting work. We were told that new members of the team always went out with experienced staff but the provider had not ensured that people using services were aware of the lack of full checks. We judged that these problems with recruitment put vulnerable people at risk.

We also looked at the arrangements in place for managing grievances and for disciplining staff. We saw that the provider had good systems in place and that guidance was available. We were also told that the new manager would receive training on these matters. We saw one example of suitable disciplinary action. We

also had evidence to show that there may have been other matters which might have gone through a grievance or disciplinary process but had not. We judged that the application of disciplinary and grievance matters needed to be improved on.

This was a breach of Regulation 19 of the Health and Social Care Act 2008; Fit and Proper Persons employed because appropriate background checks were not in place for some staff. Concerns about fitness and ability to carry out duties had not been dealt with appropriately.

We looked at the arrangements in place for staffing this service. We saw that recruitment was on-going and we met some new recruits during our visit. Turnover of staff had been high in the preceding months with approximately 15 members of staff leaving. The new manager told us that they did have enough staff to deliver care. We checked on the numbers of staff and the hours to be delivered. We judged that there were enough staff employed but we learned that a number of staff were absent through ill-health. We also met someone who told us they had "given back my work this week". The service gives staff zero hours contracts which can make the availability of staff unpredictable.

This had resulted in the manager and the care coordinators delivering care during the week we visited and we learned that they had done this at other times. On the first day of our visit there was no management staff in the office until 10.30 a.m. because of this. People we spoke to by telephone told us that they were often told that there were staff shortages. We judged that at times there were not enough staff to cover shifts but that the new manager and the provider were trying to recruit staff in suitable numbers.

We recommend that the provider review recruitment and retention policies to ensure that a stable team is created in this service

The organisation had suitable systems in place for managing and reporting accidents and incidents. We were told that there had been no staff or service user accidents that needed to be dealt with formally. We did not discover any accidents when we looked at records or when we spoke with staff and service users.

We had been informed by the local authority of a number of occasions when medicine had not been administered appropriately. We learned about one person who needed medication at specific times had been given medicines too close together. We also had information alleging that some medication had not been administered. We looked at Medication Administration Records (MARs) and we saw that in previous months these MARs had not always been completed. We look at some recent records and saw that completion of these was improving. Staff did receive training on medication administration but their competence in this had not been observed. The new manager and area manager had identified a number of files where social work requests for dealing with medicines were missing. This had not been highlighted by the previous two managers when they set up the care delivery. This was being dealt with by the new manager and she was in the process of double checking that staff were prompting or administering medication appropriately.

This was a breach of Regulation 12 of the Health and Social Care Act 2008: Safe and care treatment because the registered provider had failed to ensure the proper and safe management of medicines.

We also looked at the issues around infection control. We saw that staff received training on these matters and that suitable personal protective equipment was available for field staff. We had one concern about this which was dealt with through safeguarding and we judged that the manager had taken suitable steps to deal with this.

Requires Improvement

Is the service effective?

Our findings

We had received some comments from people using the service who thought that some staff, "Don't really know what the job is about". We also had some comments from people who thought that staff were, "very good". Service users were, in the main, positive about staff who they thought were, "trying their best." We also had some comments about staff attitude being undermined by the problems in deployment. One person said, "They are overwhelmed...too many calls and no travel time."

We had evidence to show that every member of staff had received initial training when the service started and that this training continued as new staff were recruited. This included person centred care, safeguarding, health and safety and moving and handling. The provider had mandatory training which they ensured was completed by every member of staff. We saw training records for the entire team and detailed records for individuals. We judged that training was of good standard, given that this was a relatively new service. The area manager and the new manager told us that where people had specific needs they would ask for training support from community nurses or occupational therapists.

Registered services should give individual staff members appraisal at least annually. This had not yet happened in this service which had only been operating for less than a year. The new manager told us that she planned to do this early in 2017.

When the inspection started we were told by the area manager that her audit had uncovered the fact that the previous two managers had not completed supervision with staff. The area manager, the new manager and the care coordinators had started to give staff supervision. We had evidence to show that each member of the team had received one formal supervision. We also saw that a number of staff discussions had been recorded when team members had been experiencing difficulties in undertaking their job role. We judged that the recording of these meetings needed to be done in more detail in order to help staff to develop in their role.

The provider had procedures about practical supervision of staff in the field. These observations of practice were only just beginning to happen and most staff had not had their competence checked while they were delivering care. This had not progressed despite the company having a large workforce delivering care support to people with varied and diverse needs. We saw that there were suitable systems in place but that field work supervisors, care coordinators and the new manager had not been able do this. They also needed support to develop skills in formal and observational supervision. Competence in things like delivering personal care, giving out medication and moving and handling still needed to be checked on with most of the workforce.

This was a breach of Regulation 18 of the Health and Social Care Act 2008; Staffing because the provider had failed to ensure that staff were competent, skilled and experience to deliver good standards of care.

The audits completed by the area manager, and some of the information we had received from social workers and other professionals, had highlighted problems with communication between team members.

Staff told us that they had missed calls because they had not been told of the call or the call had been missed from their list. We were unable to confirm if this had been the cause of missed calls as there was no in-depth analysis of these before October 2016.

We saw that the new manager had set up some simple systems locally to help staff communicate appropriately. She had already held some staff meetings and had discussed these issues. On the days of our visits we noted that this was a very busy branch office with staff calling in to communicate things like traffic problems, individual issues, runs being delayed and support needed. The new manager, the receptionist and care coordinators all tried very hard to act on this communication. We also saw minutes of staff meetings where the new manager had encouraged people to communicate with the management team. We noted that the introduction of supervision and the staff meetings had started to improve two-way communication.

We spoke with social work staff who told us that the service had not always informed them of issues with service users in the past but that they felt that this was improving slightly. We saw some records of the management team informing other professionals of issues with service users.

We recommend that internal and external methods of communication are reviewed and steps taken to continue to improve.

The new manager understood the principles of the Mental Capacity Act 2005 and had received some training on this. 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. The responsibilities of staff under this act were discussed in initial training.

The area manager confirmed that this service visited people in their own homes and that they did not have any services in supported living services (where sometimes staff need to consider deprivation of liberty issues). Her audits had not revealed any person who was being deprived of their liberty. She also confirmed that the service did not use restraint and that they would not take on any work that might involve behaviours that challenge.

We looked at a number of files where people had signed consent to care and support forms. Not all files contained these but the management team were working on having these completed. The service users without consent forms were clients of Adult Social Care and the social workers had discussed consent to care and support with individuals.

Some people's care files we looked at showed that the social worker had asked the service to ensure that the person was getting good levels of nutrition and hydration. We saw two records where this was the assessed need. There was a simple plan in place and we saw from notes that staff were trying to encourage people to eat. One entry said, "[the service user] fancied fish and chips...so I got some ...he ate well." We also saw that other staff tried to talk to people about foods they might want and did their best to provide it. We judged that a little more work needed to be done if people needed fortified diets but we were told by the area manager and the new manager that they were not doing any work where this was needed. They had started to record food taken with one person and the new manager was supporting staff to record in depth. Staff training covered nutritional planning in theory.

We recommend that further training and information is sourced on nutritional planning to ensure that the team can deliver this kind of support, if necessary.

We looked at care plans, daily notes and basic information kept on each person. All of the files we saw had contact details for GPs and, where necessary, other health professionals. There was some evidence to show that staff contacted the relevant health care professional if a service user was unwell. We had some information that indicated that in the past staff had not contacted health care professionals as promptly as they might but we also had evidence to show that staff now contacted GPs and community nurses in a more timely fashion. The community nursing teams for Copeland and Allerdale told us that communication had improved.

The branch office was based in a business park in Workington with suitable security. The office had the right kind of equipment to ensure the business ran smoothly. The office was open plan but there was a small office that could be used for training, supervision and small meetings. The building was suitable for people living with disabilities. The provider had a small satellite office so that staff working in Carlisle had a base they could use when necessary.

Requires Improvement

Is the service caring?

Our findings

We spoke to people about how caring they judged the service to be. We had some very positive comments about individual carers and about members of the managements and supervisory team. One person told us, "I am quite happy with the service...they do what I need. The staff are nice, very helpful...". Another person told us, "The staff are all very pleasant and nice." One relative told us, "We are happy with the service...the staff do the personal care well..."

We also had some less positive comments. We received some surveys where 32% of our respondents said they were unhappy with the way they were cared for but only 5% of those surveyed thought they were not treated with dignity and respect.

One person told us, "The previous girl has gone...she wasn't very good..." Another person said "Most are quite respectful apart from one who was rude...I am pleased they don't come any more." One person said, "The carers themselves are fine...but carers don't turn up! Office staff don't have the right attitude." One person gave us an example of a staff member who didn't turn up and claimed that they had but there was no response. One person we spoke to by telephone told us, "Carers attitude and ability is variable...some are better than others...some are brilliant ! "

Most of the less than positive comments related to missed or late calls and poor responses. One person said to us, "It isn't very respectful when they forget about you or turn up late or stay for twenty minutes when you pay for thirty." Several people said that the staff, "Tried their best" and were, "quite caring...when they turn up." A member of staff told us of a service user in their nineties who had not had a morning call, This person had been left in bed and was distressed.

We did have comments about staff being "in a rush" and "on their phones" when delivering care and support. One person said, "The staff are overloaded...one had four calls to go to other places when she was supposed to be spending time with me." We also spoke to relatives who felt that the staff who came to their relatives home did not have the right aptitude for working with older people and "Didn't know how to talk to her...how to socialise... and that's needed as well as the personal care"

We also had evidence to show that some of the failures in care delivery had impacted on individuals sense of self worth and confidence. One person told us that an incident had, "Really upset (my relative)...who felt as if she had been spoken down to about her medication when she knows perfectly well how it needs to be given."We also had evidence of a person sitting without care for a long period of time and this had impacted on their dignity as they could not care for themselves without support. People with diabetes had to wait for meals. Relatives told us that some staff "Just took what [my relative living with dementia] said and they didn't make any food."

One person told us that they had been called, "moody" by a care assistant and told, when the carer arrived late, that the service user, "Should be grateful I am here." Another person told us that they didn't like to phone the office if the call was late because the attitude wasn't good. They said, "I don't think they care at

all...I am a nuisance to them." This person also told us that things were improving slightly and the new branch manager was "better...I don't mind ringing her."

We judged that although a lot of the care delivery was done in a caring and respectful way some care was not given appropriately. We had evidence to show that due to late or missed calls or shortened calls people were not getting the care and attention needed to allow them to have the right level of person centred care. Some people told us they thought that, "Staff are so overworked and in a rush so they come over as offhand."

This was a breach of Regulation 10 of the Health and Social Care Act 2008: Dignity and respect because the delivery of care did not always ensure that people were treated in a caring, respectful and compassionate way.

Requires Improvement

Is the service responsive?

Our findings

We asked people about how responsive they judged the service to be. We had some people who were quite positive about the care provided and told us that they were, "Happy with the service". One person told us they were, "Very happy with the service and very grateful for the care given". A relative told us,"The whole family are happy with the way its going."

Other people told us that they did not judge the service to be responsive. One person told us that, "The office don't get back to you...I have asked for a change and still not had any response." People also told us that they did not have a care plan in their house. Another person said, "I have one...such as it is. The staff don't look at it anyway...they just do [the basic care] then its good bye." Staff confirmed that, "Sometimes I don't have time to read the care plan" and that, "Not all of the clients have care plans in the house...Its fine if they can tell you but not everyone can..."

We looked at a range of care files for people who had varied needs and varied lengths of visits. These were the care files kept in the office. We saw that some files had very good initial assessments in place. Other files had scant assessments of need. We also noted that some people had needs that had not been reassessed. For example one person had initially received care during a period of rehabilitation. The care delivery had not been reassessed and the care plan had not changed despite the daily log showing changes to dependency.

Some files contained details of individual needs. For example some files had very good moving and handling plans completed by occupational therapists, some files had information about specific needs. Not all files had this kind of detail and some moving and handling plans had been devised by staff who were not trained to do so.

We read a number of care plans and we saw that some were of a reasonable standard and were easy to follow and contained suitable details so that staff could deliver the care that was wanted and needed. Other files contained care plans that lacked detail and were not up to date. When we spoke to people on the telephone many of them told us that there was no care plan in their home. One person told us, "It is in the office as it needs updating...not had one for weeks." We saw a file that had been brought to the office and it did not contain a care plan but instead had notes written by care staff which did not give suitable guidance.

Staff wrote notes in daily log books. These books were only brought into the office when they were complete. We judged that the format was very good and would allow for good levels of communication within the care team. We were concerned because we were told that the written notes were only audited and analysed when they were finished and brought into the office. This meant that some daily notes had not been analysed for months. We found that only a few log books had been audited because the field care supervisors had not been able to complete monthly audits. We judged that this system did not allow for monitoring of the safe and effective delivery of care.

This was a breach of Regulation 9 of the Health and Social Care Act 2008; Person centred care because the

provider had failed to fully assess people's need and care planning and review were not being completed adequately so that safe care and treatment was provided.

We saw that staff supported people in accessing interests and activities if this was part of the care delivery that was required. There had been some issues where, due to late calls, some people had not been able to attend day centres or other activities. We judged that these concerns had been addressed but that this needs to be kept under review as part of a wider review of programming.

The service had a complaints log. We also read the complaints policies and procedures. We saw that some complaints had been dealt with appropriately by the previous managers but that one complaint in the log still needed to be resolved. We also advised the registered manager that we had received information from a relative who was unhappy with the response to a complaint. The new manager was aware of this and was dealing with the issue. Some people had told us that they were still not satisfied with the way complaints had been handled. We saw evidence to show that the new manager had discussed issues with people who had complaints and was doing her best to ensure that the matters had been resolved.

We made a recommendation that the provider review the arrangements in place to respond to complaints.

Inadequate

Is the service well-led?

Our findings

We spoke with people, their relatives and with professionals about how well led this service had been since it started in February 2016. We had information to show that people had been dissatisfied with the attitude of some management staff and with the way staff were led and resources allocated.

We phoned a number of people and spoke in some depth about the way the branch had been organised since its inception. Our expert by experience spoke to some people who were satisfied but several people expressed concern and dissatisfaction. We had also heard from service users and relatives who had been unhappy and who had taken their concerns to the local authority. Several people said that what they judged to be a poor service was due to poor management. People spoke about problems with the allocation of work, missed and shortened calls and poor responses from the office.

One person said to us, "I think they overload the staff ...I am not surprised some of them cut short my call." Another person said that when they asked for changes or informed them of late calls or shortened visits, "No one seemed that interested and didn't get back to me."

This service started in February 2016 and problems had been reported from the start related to how the operation was managed. There had been complaints and concerns forwarded to the Care Quality Commission and to the local authority. Some of these had also been taken as safeguarding matters as they related to acts of omission or neglect. The service had been supported through Cumbria County Council's quality improvement processes since May 2016.

The service had a registered manager not based in Cumbria and who was not in day to day control of the service. This arrangement was in place because it had been difficult to recruit a suitable candidate. The registered manager had delegated the task of managing this plan to two managers who had not been able to sustain the management role. A third manager had been appointed and took up the post on 1 September 2016. She was in the process of registering with the Care Quality Commission as the manager of the branch. The registered manager was in the process of applying to de-register as she was aware that she could not manage the service from a distance, given her senior role in the company.

The new manager had been a senior care coordinator in the branch since it started. She had considerable experience in care and supervision with a number of other services. She knew the local area, had a good understanding of the needs of the service users and had established links with other professionals. She told us that she was aware that she needed more support to develop her management skills. We spent two days in the branch and we observed how she dealt with staff, service users and professionals who rang the office. We also spoke with her at length about the vision and values of the organisation and about her own values. We judged that this person had good values and that she worked with staff and service users to promote the values of person centred care and high standards of care delivery. She could also identify the barriers to achieving these goals and had asked for support from the company.

We learned that management training had been identified for this new manager but that due to staffing

problems this had been postponed temporarily. The area manager had also arranged for experienced branch managers to give the new branch manager support for a minimum of six weeks. This had been identified because the provider had recognised that there was a backlog of work to be done on care planning, staff supervision and records management. These managers and the area manager would be in the service for five days a week for six weeks, It was hoped that this would allow the new manager to move things forward in the branch.

We judged that quality monitoring had not been achieved in the first six or seven months of operation. The organisation had suitable quality monitoring systems in place but the previous managers had not been using the system to monitor the delivery of care and supervision of staff. For example although telephone surveys in May and June 2016 had identified some issues there was no evidence to show that the majority of these problems had been dealt with. We saw that the area manager, who had started to work with the branch in June 2016, had completed audits of more than 100 care files and approximately 50 staff files. The audits had been in-depth, gaps and errors noted and some actions taken. For example every member of staff had received one supervision session and a number of care plans had been updated. However we saw that regular and routine monitoring of care delivery was not being done. Some issues that had been discovered had not been dealt with because some systems needed adjustment and some staff performance needed to be improved.

We looked at the arrangements in place for organising the way the programme of calls was arranged.We looked at some information that showed that staff were deployed appropriately. We had, however, received lots of comments about how the deployment of staff was not meeting people's needs. We had evidence to show that some 'runs' for individual staff did not give staff enough time to go from person to person in a timely fashion. One relative told us that they had monitored this for some weeks and found that the staff did not stay the full length of time for almost half the time. We had been told about missed, late and shortened calls prior to our inspection and we also had further information when we rang people.

One person told us that they had repeatedly asked for a later call and other people said they needed their call earlier. One person said that things had improved a little and calls were not "too late". One person told us that calls were often late or missed completely. This person told us that when they discussed this with management they were told it was a temporary shortage of staff. One person thought that "holiday times and half term is a problem to them as they cant seem to cover."

Staff told us that they were unhappy with the scheduling of visits and the time between visits. Staff also said that the timesheets for their pay sometimes did not reflect what they had done. One staff member said they had not been paid as their timesheet had not been sent to wages. We had a number of staff tell us that they were not happy with the management of the service. We had staff tell us that "someone in the office" had told them to cut the calls short so that they could finish the round. We had no evidence that this happened but we spoke to the registered manager about this unsubstantiated claim.

Staff told us that missed, late and shortened calls were not recorded as part of quality monitoring. We asked the new manager about this and she showed us copies of records that started early October 2016. There had been no record kept prior to this and no evidence that missed or shortened calls had been investigated thoroughly through quality or disciplinary processes. We could not find evidence of quality management of these calls prior to this log being kept. We had some intelligence from the local authority and the community nursing services to show that missed calls had reduced. We also had comments from service users saying, "I think things are getting better...a bit more settled and I get the same staff...more or less."

We look at a variety of records kept in the service. Records were kept in a secure fashion in locked filing

cabinets and cupboards. We found that care files were not filed in any kind of order, that many of the files needed updating, that some documents were missing but that staff in the branch were trying to update these. We also had evidence to show that although each person had a care folder in their home, some of these did not contain the care plan or other necessary documents. Some staff files also had missing information. Information about previous employment was difficult to find because previous managers had not filed this appropriately but had boxed up information in a haphazard way and placed it in a cupboard. We also noted that archived records had been treated in this way.

This was a breach of Regulation 17 ;Good governance because quality monitoring systems and processes had failed to assess, monitor and improve the quality and safety of the service.

We had been made aware of a number of safeguarding matters and other concerns. The local authority or service users had informed us of these issues. The provider had failed to send us notification of these matters. The new manager said that she would re-visit this because she had been unaware of her responsibilities in relation to this. She thought that the local authority informing us was sufficient. We saw that the previous branch managers had not notified us despite the area manager instructing them to do so.

This was a breach of Registration Regulation 18: Notification of other incidents. We will be taking further action about this separate from the inspection.

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 You have failed to notify the Care Quality commission of events that have occurred while carrying on the regulated activity.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care This is a breach of Regulation 9 of the Health and Social Care Act 2008: Person centred care because the provider had failed to fully assess people's need and care planning and review were not being completed adequately so that safe care and treatment was provided.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect This is a breach of Regulation 10 of the Health and Social Care Act 2008: Dignity and respect because the delivery of care did not always ensure that people were treated in a caring, respectful and compassionate way.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment This is a breach of Regulation 12 of the Health

and Social Care Act 2008: Safe and care treatment because you have failed to ensure the proper and safe management of medicines.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing This is a breach of Regulation 18 of the Health and Social Care Act 2008; Staffing because the provider had failed to ensure that staff were competent, skilled and experience to deliver good standards of care.

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 17 HSCA RA Regulations 2014 Good governance This is a breach of Regulation 17 ;Good governance because quality monitoring systems and processes had failed to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

We served the provider with a warning notice because they had failed to operate a suitable system to monitor the quality of care and services in the location.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed This is a breach of Regulation 19 of the Health and Social Care Act 2008; Fit and Proper Persons employed because appropriate background checks were not in place for some staff. Concerns about fitness and ability to carry out duties had not been dealt with appropriately.

The enforcement action we took:

We served the provider with a warning notice because they had failed to ensure that there were robust recruitment and disciplinary actions in place. Staff were working with vulnerable adults without suitable checks on their background.