Wii Care Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on 16 and 19 January 2017. The inspection was unannounced.

Wii Care Limited was registered to provide personal care services to people living in their own homes, mainly in the Medway, Dartford, Swanley and Gravesend areas. There was an office base in Rochester in Kent. When we last inspected the service there were 158 people receiving a service. At this inspection there were 82 people receiving a service. Some people lived with relatives and some lived alone in the community. Some people received their care in bed.

The service had a registered 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. The registered manager was also the registered provider of the service.

At our previous inspection on 12 and 13 September 2016, we found breaches of Regulations 9, 12, 16, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to provide care and support which met people's needs and preferences. Medicines had not been properly managed. Risks to people had not been adequately assessed. Complaints had not been dealt with effectively. Systems to monitor quality and safety were not always operated effectively and records were not always accurate and complete. Sufficient numbers of staff were not employed to be able to provide the assessed personal care needs of people using the service. We asked the provider to take action to meet Regulations 9, 12 and 16. We took action against the provider and told them to meet regulation 17 and 18 by 03 January 2017. At this inspection we found that the necessary improvements had not been made.

We received an action plan on 02 December 2016 which stated that the provider planned to meet Regulation 9, 12 and 16 by the 31 December 2016. At this inspection we found the provider had not implemented the improvements they had identified on their action plan.

The provider had reduced the numbers of people they were supporting since the last inspection which had relieved some of the pressure in some areas. However, we found that staff were continuing to have too many care visits to make as there were still insufficient numbers of staff available to deliver the amount of care visits required. Rotas were inaccurate, showing individual staff working in more than one person's home at the same time. We were told, and we saw evidence to suggest that staff were regularly delivering care on their own to people who had been assessed as requiring two members of staff to support them.

Although there had been an improvement in the medicines administration records, we found that records were still not accurate, leading to unsafe practice. Many items were administered and not recorded and sufficient guidance was not always in place for 'as and when necessary' (PRN) medicines.

Accidents and incidents had not been reported in many cases and those that had been reported had not been documented to ensure an accurate record was kept to keep people safe, to learn from mistakes and to check trends.

Individual risks had not been identified to keep people safe from harm. This meant that control measures to reduce the risks to people had not been recorded for staff to follow. Environmental and general risks that were relevant to everyone had been identified.

The provider had not carried out sufficient checks on new staff before they started employment to ensure they were suitable to work with vulnerable people. We did not find evidence that new staff had worked with the correct supervision while waiting for recruitment checks to be finalised.

The provider had safeguarding procedures in place for staff to follow to keep people safe. Staff knew what signs to look out for that might suggest people were at risk of harm. Staff were able to describe what they would do if they had concerns and who they would report these to.

People's capacity to make their own choices and decisions had not been considered following the principles of the Mental Capacity Act 2005. Family members were often asked to sign consent forms without an assessment being undertaken to determine the person's capacity first. There was no evidence that decisions had been made in the person's best interests.

Although staff supported some people at lunchtime by making and serving their meals, we found that lunchtime visits were very often far shorter than the time that had been assessed to carry out this task. There were no specific risk assessments or care plans for individual people who may be at risk of malnutrition and required staff support at mealtimes.

There was insufficient recording of people's health needs. Where people had a clear health issue that needed the attention of a health care professional, communication and documentation was poor at each care visit and between care staff and office staff. This led to uncertainty whether people had actually been referred for the appropriate health care.

Staff received support through one to one supervision meetings although this was not consistent for all staff. There was no clear line management structure to enable staff to have a named line manager to ensure clear lines of responsibility and accountability.

The provider employed an in house trainer and staff did receive training in the areas relevant to their role. However, we found that staff attended as many as 15 or 16 training courses in one day. We made a recommendation about this.

People, their family members and staff told us that the many of the newer staff in particular did not seem to have the knowledge they required to carry out their role.

People told us they thought the staff were generally caring and they enjoyed their visits. However, the evidence we found was that visits were often cut short or delivered by one member of staff when two were required. People were therefore not given the time and care needed to be able to maintain their independence and dignity.

Staff supported people whilst maintaining their privacy. Confidential records were securely stored.

Complaints were poorly managed by staff and the provider. A complaints procedure was in place detailing the process of how to make a complaint and how it would be handled and responded to. However, the provider did not follow their own procedure. We found many complaints made and not responded to and many that had not been recorded.

People had an assessment before support commenced and care plans were developed to document the support people required. However, although people stated the times they wanted their support during their assessment, these times were often not adhered to, instead people received their support at times to suit the rota. Care plans were not always reviewed to update information where people needs had changed which meant that people were receiving different support to that described in their care plan.

The provider had not made any improvements to the processes in place to monitor the quality and safety of the service provided. None of the issues we found during our inspection had been picked up by the provider. The provider had undertaken quality audits in some areas but these had not been robust enough to capture the action required to improve the service. Lessons had not been learnt from complaints or accidents and incidents in order to prevent further concerns and to strive for improvement.

Accurate records were not kept either by care staff, office staff or the provider to ensure good communication and the safety of people supported in their own homes.

We found nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the registered provider to take at the back of the full version of the report.

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.

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.

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.

Accidents and incidents were not recorded or reported appropriately to learn lessons to be able to keep people safe.

Risks to people's safety and welfare were not always well managed to make sure they were protected from harm.

Suitable numbers of staff were not available to provide the assessed care needs of people living in their own homes.

Medicines administration records were not completed correctly and information and guidance for staff was not always available.

Safe recruitment processes were not in place to make sure new staff were suitable to work with people alone in the community.

Is the service effective?

Inadequate

The service was not effective.

Staff training was not always effective as staff were completing many training courses in one day.

The principles of the Mental Capacity Act 2005 were not followed to ensure capacity assessments were undertaken and decisions were made in people's best interests.

Nutrition and hydration needs were not suitably assessed and enough time given at mealtimes to ensure people had a relaxed meal with time to finish.

People's health needs were not always assessed appropriately and it was not evident that referrals to healthcare professionals had been made.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not given the time to be able to maintain their

dignity and independence as visits were often rushed and cut short.

People spoke well about most of the staff and looked forward to their visits.

The provider had a service user guide to give to people at the commencement of their support detailing the information they needed about the service.

Is the service responsive?

Requires Improvement

The service was not responsive.

Complaints were either not recorded at all or those that were had not been responded to appropriately.

Assessments were undertaken before support commenced but care was not always delivered in the way people wanted due to time restraints, nor at their stated preferred times.

Care plans did not always capture individual information and reviews were not effective.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not improved the systems and processes to audit, monitor and improve the quality and safety of the service provided.

Records were not accurate and complete.

Lessons were not learned from complaints, accidents and incidents.

Feedback from people and their family members had not been acted upon to improve the delivery of service.

The provider had not reported incidents to CQC. The provider had not displayed the rating from the last inspection on their website.

Wii Care Limited

Detailed findings

Background to this inspection

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

This inspection took place on 16 and 19 January 2017 and was unannounced.

The inspection team consisted of two inspectors and three experts by experience. The experts by experience made telephone calls to people and their relatives. An expert by experience is a person who has personal experience of using similar services or caring for family members.

Before the inspection, we reviewed previous inspection reports, information from whistle blowers, complaints and concerns that had been passed to us by people, relatives and the local authorities.

We spoke with 12 staff including care staff, assessors, coordinators, human resources staff, finance staff and the registered manager.

Our experts by experience telephoned 17 people to ask them about their views and experiences of receiving care. We spoke with 18 relatives on the telephone.

We contacted health and social care professionals including the local authorities' quality assurance team and care managers to obtain feedback about their experience of the service.

We looked at records held by the provider and care records. These included 15 people's care records, medicines records, risk assessments, staff rotas, six staff recruitment records, meeting minutes, quality audits, policies and procedures.

We asked the registered manager to send additional information after the inspection visit, including training records and some contact telephone numbers. The information we requested was sent to us in a timely manner.

Inadequate

Is the service safe?

Our findings

At our previous inspection on 12 and 13 September 2016, we found breaches of Regulation 9, 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to provide care and support which met people's needs and preferences. Medicines had not been properly managed. Risks to people had not been adequately assessed. Sufficient numbers of staff were not employed to be able to provide the assessed personal care needs of people using the service. We asked the provider to take action to meet Regulations 9 and 12. We took action against the provider and told them to meet Regulation 18 by 03 January 2017. The provider sent us an action plan on 02 December 2016 which stated that they planned to meet Regulations 9 and 12 by the 31 December 2016.

The people we spoke with gave us mixed feedback about the staff. People liked the regular staff who came into their home to support them and generally felt safe with them. One person said, "The carers, on the whole, are very good". Another person told us, "I feel safe always''. However, many of the people we spoke to were not as comfortable with the newer staff. One person said, "I feel 50/50 safe with them. Some are good but you have to watch them regarding medicines. I spotted mistakes".

Relatives were less positive about their loved ones safety. One relative told us, "She isn't safe all the time. They are not trained to lift in [using] the hoist. Only one [staff member] turned up for a hoist [care call where staff were required to hoist a person] and we had to wait until they found another carer at short notice". Another family member said, "I don't feel confident that the staff know how to look after her. The girls [staff] are ok but sometimes only one comes when two are needed. They do explain there are staffing problems, but I am the back up! They don't always stay the allotted time".

At the last inspection we found that medicines were not well managed. At this inspection we found that this had not improved. Medicines administration records (MAR) had not always been documented appropriately. The provider had introduced a new MAR chart in November 2016 which was clearer and had been better recorded by staff. These MAR charts covered a three month time period which was due to end at the end of January 2017. We requested copies of these MAR charts from some people's homes. These had been completed up to and including 18 January 2017.

Medicines were not consistently documented when administered. Blister packs containing people's prescribed medicines had been set up by a pharmacist. The blister packs were recorded on the MAR chart, along with the frequency the medicines in the blister pack should be administered by staff. Some of these were not administered as described on the MAR chart. One person had two blister packs, one of the blister packs stated it was to be administered four times a day, however the MAR chart was only signed by staff three times a day. The other blister pack stated it should be given four times a day, when it was signed as administered only twice a day. Staff had recorded on one person's daily records sheet on 26 November 2016 that they had given the person an antibiotic medicine. No reasons were recorded why the person had commenced antibiotics and who had prescribed them. The MAR chart had not been updated to include the prescribed antibiotics until 28 November 2016 when a new MAR chart was commenced, so there were two days when there was no evidence the antibiotics had been administered. No further recording about

administering antibiotics had been made on the daily record sheets.

There were many examples of creams and ointments being administered on a daily basis by staff. Although they recorded that this was the case in the daily record sheets, in some cases no MAR charts were present to formally record the administration of creams and to ensure they were applied as prescribed. In other cases where a MAR chart was present, staff signed it ad-hoc. On one person's MAR chart staff had signed only 16 times in one month. Another person who only had cream administered by staff and no other medicines had a MAR chart with the cream recorded on it. However, the chart was completed erratically and on a number of occasions not signed by staff at all. For example, week commencing 28 November 2016 the chart was fully completed but week commencing 21 November 2016 only one signature was recorded, and week commencing 5 December 2016 only two days had staff signatures. No body maps were in place to show where staff were required to administer creams. This meant that people may not receive their medicines and creams as prescribed as it was unclear whether staff had administered them or not.

One person was prescribed Paracetamol. Their MAR chart showed that on occasions they had been given their doses too close together. For example, on 15 November 2016 they had received a dose at 15:10 and they had then received another dose at 17:23. This meant that they had received another dose of Paracetamol two hours and 13 minutes later. Adults can usually take one or two 500mg tablets every four to six hours, but should not take more than eight 500mg tablets in the space of 24 hours. Taking medicines too close together puts people at risk of harm.

This failure to ensure that medicines were suitably administered and recorded was a breach of Regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found that the provider had not deployed enough staff to provide assessed care and support. At this inspection we found this had not improved. We checked rotas for a number of staff from mid-November 2016 up to 19 January 2017. The provider did not have sufficient staff to provide the personal care that people were assessed as needing. We looked at a large number of staff rotas. Rotas showed that staff had been allocated time for travelling between visits. However, the length of time to travel between visits was not adequate. For example, we checked online route planners and maps and found that a number of the journeys would have taken between 15 and 20 minutes. The rotas showed that staff had been allocated five minutes to make the journey. We spoke with the office staff who agreed that the journeys would not be possible within five minutes. Some rotas showed that there was no travel time between care visits. For example, the care visits were scheduled back to back. So the staff member should finish with one person's call at 19:30 but be at the next person's care call at 19:30.

Many rotas showed staff had too many visits a day to cover. In some cases the amount of visits booked on the staff member's rota would not be possible to deliver. Some staff rotas showed they had been allocated to work with up to five different people at five different addresses at the same time. For example, one staff member was scheduled to work on 02 January 2017 with one person in Gravesend at 19:00 to 19:30 and another person in Northfleet at 19:00 to 19:30. Some care visits had been scheduled to overlap. For example, one staff member was scheduled to work 16:10 to 16:40 with one person but 16:30 to 17:00 with another. One staff member's rota showed they were scheduled to work in four places at once on 04 January 2017. All four care visits had been scheduled to be between 19:30 to 20:00.

Many other staff members had similar rotas with far more visits than they would have been able to cover in the times allocated. One staff member had 34 care calls scheduled on their rota on 01 January 2017, which would have taken them 18 hours to complete (which did not include travel time between each call). The call log showed they had completed all of the care visits including travel time) in 17 and a half hours. Another

staff member had been allocated 27 care calls on 19 November 2016 which in total would have amounted to 14 and a half hours (without travel time). They had completed the care visits with travel time in seven and a half hours. This evidences that people's care visits had been cut short. The provider had a logging in and out system. Staff logged in and out of people's homes using an application on their smart phones to log the time they had spent with people. We found that staff were logging in and out of people's homes at the same time, which would have been impossible. For example one staff rota showed that a staff member had logged in to one person's home at 06:00 on 02 January 2017 and logged out at 06:30 but had logged in to another person's home at 06:00 to 06:45.

People and their relatives made contact with us before we inspected the service and during the inspection to tell us that staff were not spending the right amount of time on their care calls. They told us that staff were recording that they had been at their homes for longer than they had. One relative told us they had observed staff visit their family member on 15 January 2017. The staff had arrived at 16:10 and left at 16:20. The relative checked the records that the staff had made and they had recorded they had been there 17:00 to 17:30. Some staff we spoke to confirmed this was the case. They told us that they knew of some staff who visited people for shorter amounts of time than they should and recorded that they had stayed for the length of time on their rota. We were told that it was sometimes unavoidable as they often had so many visits to do in one shift. Some staff also said that it had often been the case that only one member of staff would visit to support people who had been assessed as needing two staff to support them. Some people and their relatives we spoke to confirmed this was the case. This put people and staff at risk of unsafe moving and handling practice.

We looked at 11 people's invoices for the month of November 2016. The provider had sent these invoices to local authorities for payment for people's support. The invoices showed that payment requested each time was for the full assessed and allocated times, not for the actual care received. We spoke with the person responsible for producing and processing invoices. They told us they took the information about time worked from the computerised system (People planner). They confirmed that they "Expect the people planner to be correct. I wouldn't have time to audit information". We checked with them what they meant. They confirmed that they processed invoices without checking the system for accuracy. Therefore, they were not picking up that staff were logging in and out of different people's homes at the same time.

The provider had failed to deploy sufficient staff numbers. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

At the last inspection, we found Individual risks were not always identified to ensure measures were put in place to keep people safe. At this inspection, we found that individual risks had not been identified for most people. For example, where one person was at risk of falls an individual risk assessment had not been undertaken to establish the risk to that individual and what staff could do to minimise the risk. This meant that staff did not have all the information available to them to make sure they could support people in a way that safeguarded them from potential harm. There were no specific individual risks identified for one person who was cared for in bed. Such as a moving and handling risk assessment to keep the person safe from harm when receiving full personal care and to safeguard the staff when delivering personal care. We asked one of the assessors about individual risk assessments and if they were recorded elsewhere. They told us that there was no further documentation and agreed the risk assessment process did not identify individual risks. They said that the new recording system the provider planned to implement would lead to more robust risk assessments. However, they agreed that people were not kept safe from harm by good risk management systems before that system was in place.

Although some accidents and incidents had been recorded, there was no consistent approach to the

reporting and recording of incidents. We were told by the coordinators that when an incident was reported to the office, whoever took the call would record the incident on their electronic system and a copy of an incident form would be kept in the person's care file. However, we found clear examples of incidents that had occurred when staff were in people's homes and they were either not reported by care staff or not recorded by office staff. One example of an incident at one person's home, a staff member documented in the daily record sheet, 'Refused care, kicked out'. There was no record of this having been reported to the office or recorded as an incident, no further details documented and no follow up as to what action was taken. This meant the registered manager was not always aware of incidents that had occurred to be able to monitor concerns and improve the service delivered accordingly. People were not kept safe from accidents and incidents as there was no robust recording system to ensure follow up by the registered manager and no investigation recording to establish why incidents happened and what action was taken to reduce the likelihood of them occurring again.

We received information before we inspected the service to detail that staff did not always use equipment that people had been assessed as needing. This meant staff had not worked in a safe way. This put people and staff at risk of harm.

This failure to manage risks to people was a breach of Regulation 12(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not always carried out safe recruitment practice. All of the staff recruitment records contained photographs of staff. The provider had employed new staff since the last inspection and had not checked reasons for gaps in employment for two out of six staff. One new staff member had a gap of 15 years in their employment history. Another had a gap of six years in their employment history which had not been explored. Staff had started work before relevant checks had been made through the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. References had been received by the provider for all new employees; however there were often long delays in receiving these. Staffing rotas and schedules showed that five staff had been assigned to work with people before their DBS and references had been received. We checked with office staff and checked rotas, schedules and people's daily records, we could not always find evidence that staff without relevant employment checks had worked with suitable supervision. Therefore, the provider had not carried out sufficient checks to ensure the staff members were suitable to work around people who needed safeguarding from harm.

This failure to carry out employment checks was a breach of Regulation 19 (2)(a)(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had completed safeguarding adults training. The staff training records showed that all staff had completed training. Although five staff had not received any update of safeguarding training since 2013. Staff understood the various types of abuse to look out for to make sure people were protected from harm. They knew who to report any concerns to and had access to the whistleblowing policy. Staff all told us they were confident that any concerns would be dealt with appropriately. Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. The provider knew how to report any safeguarding concerns to the local authority. However they had not reported concerns in relating to people not receiving their care, which meant that people were at risk of harm.

Inadequate

Is the service effective?

Our findings

Although most people were complimentary about the staff and were grateful for their time and support, we were also told that they did not think that all staff were trained well and knowledgeable. Many people told us that the staff who had been working with Wii Care for some time knew what to do, but most people felt newer staff were not always competent. One person told us, "I don't feel very confident that the staff know how to look after me as they have lost so many of the long standing carers and are employing new people who don't seem to know what to do". Another person told us, "There are too many unqualified people [staff]". And yet another person said, "Slowly and surely most good staff have left over the last 6 months", and that they were, "Getting more and more dissatisfied every month".

Relatives had a similar view. One relative said, "New staff don't seem to know what to do, and I have to help him after they have gone".

The registered provider had a training schedule that showed all the training staff had undertaken. It showed most staff were up to date with the training they required to support people in their own homes in the community. The provider had a dedicated trainer who had the responsibility of training all staff. All the training undertaken was face to face or by DVD at the office and all courses were delivered by the same trainer. Some staff said they were happy with the training they received and felt equipped to support people. Staff told us the training for new staff was two weeks. However, some staff said they did not think the training was adequate and said the training was three to four days maximum. Some staff also said they did not think some of the newer staff had the correct level of skill and knowledge required to support people adequately. The training schedule showed that six new staff that had started working at Wii Care in the last six months had received either three days or four days training, with usually between five to 10 training courses undertaken in one day. We viewed the first aid certificate which staff had been presented with once they had completed their training. This showed that the course should take three and a half hours to complete. However, the course had been completed with four other training courses in one day for a number of staff. The training schedule also showed that 16 staff had undertaken 15 or more training courses in one day. This showed that staff were not given adequate time to learn and absorb the information required to support people appropriately, particularly new staff who had no experience of working in a care setting.

We recommend that the provider reviews training for staff, based on current best practice, to ensure staff have the skills and knowledge to carry out their roles to meet people's assessed needs.

A 'Consent to care' was evident for each person within their file. However, this was often signed by a family member rather than the person themselves. There was no explanation as to why this was the case. Mental capacity assessments had not taken place to assess people's capacity to be able to consent to the care they were receiving. Therefore, people were not always signing their own consent forms when they actually had the capacity to do so. We found no evidence that mental capacity assessments had been considered or undertaken. There was no evidence that where people may lack capacity to make specific choices and decisions that decisions had been made in their best interests. For example, decisions around staff visiting

people in their home to support with their personal care or for staff to have access to their home using a key safe.

This failure to provide care and treatment with the consent of the relevant person was a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Many people and their families made their own arrangements for cooking and serving meals. Staff did support some people at meal times. This was clear within the care plan and within the daily tasks document. However, there were no specific assessments or care planning around personal risks of malnutrition or dehydration, particularly where people lived alone. No guidance was available for staff directing them what action to take if people refused their food or appeared to have no appetite. There was evidence that lunchtime visits were shorter than the amount of time allocated through people's assessment of needs. Lunchtime visit times also varied and were often not at people's preferred times. The times for one person's lunchtime visits varied from staff arriving at 11:25 to as late as 14:50 in one seven day period in November 2016. Their preferred lunchtime visits had been recorded in their assessment and care plan as 13:00 to 13:30. Staff had visited at this preferred time once only in the seven day period. Another person had been assessed as requiring a 30 minute visit at lunchtime and expressed their preferred times to have their lunch was between 12:00 and 12:30. Over a seven day period from 14 November 2016 to 20 November 2016 the person's lunchtime visits were, all except one, far less than the 30 minutes required to prepare and serve them lunch. Visit times were recorded by staff in this period were; 12:13 to 12:30, 12:03 to 12:16, 11:22 to 11:36, 12:25 to 12:40, 13:18 to 13:35, 12:18 to 12:50 and 13:13 to 13:32. With an average of 18 minutes support given, most visits less than this, staff would not have had the time to ensure the person, who needed full support, had a relaxed meal or had the time to assess the person's nutritional needs had been met to make an accurate recording. This meant that people's meal time experiences were poor.

Very little information was recorded in people's care plans to document the support they required to maintain their health and well-being. Some people had relatives or friends who helped them to make appointments with health care professionals and to attend appointments. Some people who did not have family members to help required the support of staff to assist them with their health care. It was not always clear in the care plan what specific individual support each person required. Staff had recorded in one person's daily record sheets that the person had an acute health issue, this was something that clearly needed addressing by a health care professional promptly. The staff member stated in the daily record sheet they had informed the office. No further recording was made by staff about this concern until three days later when it was raised again. The person had also developed a red area on their skin at this time that was recorded as a concern by one member of staff. Staff recorded that they applied a cream that the person had not been prescribed and had no MAR chart for. No other action was recorded as having been taken. Three further visits were attended by staff with no mention of the health concern previously documented. On the fourth visit, a recording by staff stated, 'Put cream on, still bleeding'. We asked one of the coordinators to look at the call logs in the office on the computer system to check what action had been taken. Although the coordinator confirmed this would have been recorded on the computer system for that person, they could find no record of any calls made to the office or any action that had been taken. When checking the MAR chart we could see the person had been prescribed antibiotics, there was no record of how this had happened, whether the staff had contacted the GP, or the office staff, or someone else entirely had done this. Recordings by staff did not show they had discussed any concerns they had with people in order to come to an agreed plan of action. Reasonable efforts were not made to ensure people's preferences of treatment and action were taken into account. Communication and recording was not robust to ensure people received the best possible care and treatment at every visit.

The failure to provide care and treatment to meet people's needs was a breach of Regulation 9

(1)(a)(b)(c)(2)(3)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The coordinators and assessors carried out 'spot checks' of staff when they were providing care in people's homes in the community. Feedback was given to staff how they had performed and any improvements they needed to make in their practice. Staff also received support through supervision with a member of office staff. Some of these were face to face and some were over the telephone. Staff also had an annual appraisal to discuss their development needs for the coming year and to reflect on the previous year. Supervisions and annual appraisals were carried out by two members of office staff who were not actually line managers of any of the care staff. This meant that staff did not have the opportunity to develop a relationship with a line manager who had the experience to guide them in the right direction and support their individual development needs. Responsibilities and accountabilities were not clear due to the lack of a sound line management structure.

The lack of experienced and qualified staff to carry out supervisions for care staff evidences a breach of Regulation 18(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

People told us they thought the staff were caring and kind. Many people said they had regular staff quite often and this made them feel more confident. One person said, "The carers, on the whole, are very good". Another told us, "There are good people in the team''. Most people voiced a concern that a lot of staff had left recently, so they had lost staff they had known well.

Relatives also generally thought the staff themselves were caring and knew their loved ones reasonably well. One family member said, "Mother likes them so that's all that matters", and another said, "They know her and they care".

Although we received mainly positive feedback from people about the staff. The evidence from the inspection shows that people were not always treated with dignity and respect. People received care in a hurried and rushed manner because staff were rushing to get to the next person. Some people and their relatives told us that staff often turned up late and were then having to rush. Staff didn't spend time with people to chat and engage in meaningful conversation when they were rushing a person. Some records showed that staff carried out personal care calls, including making drinks and food in very short times such as seven minutes, nine minutes and 11 minutes.

Although some staff told us they gave people the time to do as much as possible for themselves to preserve their dignity and respect by maintaining their independence, we did not find evidence of this. Some staff did say to us that visits were often shorter than they should be, because they had too many to get around due to lack of staff. Most visits to people's homes were shorter than they should be rather than longer so it would be difficult for staff to be able to give people the time to maintain independence.

Some staff told us that they had been to visit people who had not had the care they should have received on earlier visits in the day and it was obvious to them. However, staff had written in the daily care records that they had carried out tasks that had clearly not taken place.

This failure to treat people with dignity and respect was a breach of Regulation 10 (1)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff maintained people's privacy. Staff explained that they would close doors and curtains when providing personal care to people. Staff explained how they chatted to people whilst providing care which made people feel valued. All of the staff explained that they covered people with towels whilst they were assisting them with their personal care to protect their privacy and dignity. One staff member said, "I would close curtains, leave the room if needed, follow the wishes of the client. I ask what they would like to wear, take clothes out for them to choose. Just because they have dementia doesn't mean to say they haven't got a choice". Another staff member told us, "When washing [a person] I cover them with towel and make sure curtains and doors are closed".

People were given a service user guide at the commencement of their support. This detailed the information

they needed to know about the service provided and what to expect. Information such as how to make a complaint and who to was incorporated into the guide.

The staff we spoke to spoke with fondness about the people they supported and tended to know people well. One staff member told us they had recently had to say good bye to some people who were leaving Wii Care Limited's services. She said, "It was really sad saying goodbye to the people that left us recently. Some were in tears saying goodbye and we nearly were too. I will really miss them, as I knew them really well".

People's information was treated confidentially. Personal records were stored securely. People's individual care records were stored in a locked cabinets in the office to make sure they were accessible to staff. Files held on the computer system were only accessible to staff that had the password.

Requires Improvement

Is the service responsive?

Our findings

Some people said they didn't make any complaints and had no reason to complain. Those that had made a complaint were not happy with the response, or lack of response they had received. One person said, "I mention issues (about punctuality) to daily carers who are very apologetic but they can't really help".

Relatives were more vocal in what they saw as poor responses to complaints or concerns raised. One family member told us, "They circle 'happy' when they haven't asked my mother". Relatives also told us that their complaints had either not been treated respectfully or had not been responded to at all.

The provider had a complaints procedure that described the process people should follow if they had a complaint. The information provided included who people could go to outside of the organisation if they felt their complaint was not dealt with appropriately. However, the provider did not follow their own complaints procedure. The provider had a complaints file that was neatly divided into months of the year in order to search for complaints easily. The complaints file clearly stated when no complaints had been received within a month period, which was most months. One complaint was logged for September 2016 when a person had complained of late and missed visits so cancelled all their planned visits and eventually left the service. However, no action had been taken to resolve the complaint and no attempt to learn lessons from the person's experience. One complaint was logged as being made in November 2016 and again that person left the service and no action had been taken to learn from the complaint highlighted, which again was regarding shortened, late and missed visits.

Complaints were often not recorded when people or their relatives made a complaint and were not followed up according to the provider's complaints procedure. We saw examples of complaints that had been made and no records of how the complaint had been dealt with, or if it had, what action had been taken. One person's relative made a lengthy and serious complaint by email to the deputy manager on 29 September 2016. The deputy manager replied the same day acknowledging receipt of the complaint and stating their email would be passed to the provider. The email was only forwarded to the provider on 04 October 2016 following the same relative raising the same issues when asked to complete a satisfaction questionnaire by telephone. There was nothing further recorded about this complaint. We asked the provider about this and he said that a coordinator met with the relative and resolved the complaint. However there was no evidence of this. Another person had also made a complaint in September 2016 about the poor service provided to them. There was no evidence that the complaints process had been followed, that an investigation had taken place or any action had been taken. When we asked the provider about this they agreed there was no record made of the complaint or any action taken. The person had since left the service. Another relative had made a complaint to the service on 15 January 2017. This had not been documented as a complaint and had not been followed up. As the relative had not received a response to their complaint they then had to make calls to the provider direct and the local authority care manager to ensure that the complaint was taken seriously. The people and family members we spoke to gave many examples of late and shortened visits. Many had complained but they were often not responded to or they felt they were not treated respectfully by having their complaints taken seriously. Sometimes people were told changes would be made in answer to their complaint but nothing did and they had no further contact from the office staff. The

provider and staff did not act on complaints received, did not follow their own complaints procedure and had no way of learning lessons in order to improve the service provided.

The provider had failed to act on complaints and feedback about the service. This was a breach of Regulation 16(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An assessment of people's care needs was carried out prior to support commencing. The provider employed two care assessors who visited people to carry out the assessment. People and their family members where this was their wish, were involved in their assessment and had the opportunity to state the times they wanted to have their support. People and their family members told the assessors how they wanted staff to support them and also important information such as how to access their property safely if the person was not able to answer the door themselves. However, we found that although people clearly stated their preferred times of support, these times were not often honoured once support commenced. The time of people's support was dependent on how many other people a staff member had to support and where they lived in relation to those other people. In other words, the rota was completed without reference to people's preferred time slots and their own individual needs and wishes. One person received care in the morning and evening to assist them with their medicines and personal care. They had been scheduled to receive a care visit on 06 January 2017 at 09:25 but had received their care visit at 14:30. This meant that they had received their care five hours late.

Care plans were in place that included a daily task sheet for staff to follow when they visited people to deliver their care and support. The daily task sheet described how staff were expected to support people on each visit. For example, the morning visit guidance included if the person required a bath, shower or full body wash and what they would normally eat for breakfast. One person's assessment stated they needed to use a hoist to move around with two staff supporting. Within their care plan and the daily record sheets completed by staff, it was clear the person was not assisted by the use of a hoist. We asked about this and were told the person had now progressed and did not need a hoist or two people to support them. However, this was not documented anywhere, the care plan had not been reviewed to document the changes. People's assessments and care plans did not detail their nutritional and hydration needs. For example, some people were cared for in bed and relied on staff to make and prepare food and drinks to keep them suitably hydrated. This meant that assessments and care plans did not give clear information to staff about how to meet people's assessed needs.

Another person was diagnosed with epilepsy, their care and support plan did not give staff information about what the person's normal seizures looked like, what to do if the person had a seizure and how to record the seizure. This put this person at risk of harm by staff not knowing how to respond to their needs.

Care plans were not always consistent. Some care plans did not detail peoples' life histories and important information such as previous occupations, places they had lived and important people in their lives. This information would help new staff understand the individual's history and help staff engage the person in discussion that was important to them. It would also enable staff to develop a good rapport with the person as well as a good understanding of their life.

The failure to provide care and treatment which met their needs was a breach of Regulation 9 (1)(a)(b)(c)(2)(3)(a)(b)(c)(h)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our previous inspection on 12 and 13 September 2016, we found breaches of Regulation 16 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to establish and operate a suitable system to identify, receive, record, handle and respond to complaints. The provider had failed to establish and operate systems to effectively assess, monitor and improve the quality of the services provided. The provider had failed to maintain accurate and complete records. The provider had failed to seek and act on feedback from people and failed to improve their practice in relation to feedback received. We asked the provider to take action to meet Regulation 16. We took action against the provider and told them to meet Regulation 17 by 03 January 2017. The provider sent us an action plan on 02 December 2016 which stated that they planned to meet Regulation 16 by the 31 December 2016.

The provider had failed to meet the warning notices they had been served by 03 January 2017. Systems to improve the service had not yet been implemented. The provider told us that there had been delays to these systems.

At this inspection, we found that systems and processes to effectively manage the service had not improved.

People had mixed views about the management of the service. One person said, "The care is ok but the structure leaves a lot to be desired". Another person told us, "I think they have office problems, as it's not staffed well enough". Some people were happy enough with the service they received. One person said, "I would be quite happy to ring the office if I have a problem".

Relatives were more candid in their view of the management of the service. Many comments were made by relatives, these included, "I think they struggle on a management level", and "I have tried to chat to the owner but he won't come to the phone, they guard him well''.

There were many concerns raised from people and family members about late and missed visits, the lack of response from the on call service and not being able to get a response from the registered provider to their concerns or complaints. People also knew that staff had often not been paid on time and had heard that staff had left for this reason. Some people said they were anxious about this as it made them feel less secure in case more staff they knew left. People were also concerned about the welfare of the staff.

At this inspection we found the provider had some audit systems in place. However, the provider's audits had failed to identify and action the areas of concern found during the inspection. For example, they had failed to capture that the recruitment records did not fully detail each employee's full employment history and reasons for gaps. The audits had not evidenced the concerns relating to risk management, medicines administration, staffing levels, capacity and consent, staff training, supervision, dignity and respect, healthcare, care plans, complaints management.

A medicines audit was undertaken every three months. An audit had been undertaken in September 2016 and the next one was in December 2016. The December audit had been carried out by the provider. He

checked the medicine records for every person supported, on the same day. The audit document consisted of two pages of areas to check. There were a number of audits undertaken where the second page had not been completed. Of all the audits carried out, the auditor had ticked that everything was in place with no issues found and no action to take. However, we found a number of discrepancies in the recording of the MAR charts we looked at that had not been picked up by the provider's medicines audit.

An audit of care files was undertaken in December 2016. The audit was planned to be undertaken once a month, although the December audit was the first one undertaken since the last inspection in September 2016. The audit was undertaken by the provider. The audit was very basic with no list of what areas were checked during the audit process. The care file of every person supported was recorded as being 'compliant' with no issues found and no actions required. However, we found issues within care files that had not been picked up by the audit, such as individual risk assessments not being undertaken, no mental capacity assessments had been carried out, incidents that had happened and not reported and complaints made that had not been investigated and recorded.

The evidence within the staffing rotas and daily record sheets was clear that people did not always get their allocated and assessed care visit times. Some people who should have had four visits a day only had three visits documented on many days and some days only one or two. When we spoke to the coordinators about one person they said this was because the person refused entry at times. However, this was not clearly documented by staff and not clear within the care plan that this was a risk. Another person's care plan stated they had been assessed as needing four visits a day, however, the daily record sheets that staff completed showed that they received three visits a day. In a seven day period, it was recorded the person had received three visits on five of the days, four visits on one day and one visit on the other day. Staff had not recorded if the care plan had changed or if there were other reasons for the person to receive fewer visits than they had been assessed as needing.

Adequate systems were not in place to monitor all accidents and incidents. It was not always evident that the provider had reviewed accidents and incidents to ensure action was taken. We asked the provider about the recording of accidents and incidents and how this should be done. They confirmed they should be logged on to the computer recording system and an incident form completed and filed. We told the provider that no incidents had been recorded since June 2016 and we had found incidents that had happened and not been recorded. They described what should have happened and all staff were trained in incident reporting. We asked the provider if they monitored accidents and incidents to make sure they were recorded and investigated appropriately and they said that they did not do this at the present time.

Accurate records were not always kept to ensure the quality and safety of the service provided and to ensure good communication across the staff team. The provider had an out of hours on call service available for people and staff to access in case of emergencies. The on call service was manned by the same two staff members every evening/night and weekend, each covering a geographical patch. There was no on call pack available to log calls as they were taken. We spoke to one of the staff who provided the on call service who told us they would log any calls received straight on to the computer recording system. They told us they could access the computer system from their home. However, they may not be at home if they received a call as they were on call constantly and had personal lives to attend to. We had been made aware of an incident with a person receiving support in their own home four days previous to our visit, and a complaint was made by a family member via the on call system. We asked the staff member who had been on call that evening about this. They remembered the call and could tell us the action they had taken. However, when we asked for them to show us this on the computer system, there was no written record made.

Accurate records were not made by staff of the care provided to people in their homes. Staff could not

possibly have provided care and support to people at the times they had recorded because they could not be in more than one place at a time. Staff had been told that they must spend the full allotted time with people otherwise they would be fined by the provider. However the rota systems in place meant that the staff could not possibly provide the full length of call. Staff were however documenting that they were staying the full length of time when they had not always done so.

The provider had a 'Missed calls' log in place. Office staff recorded when a visit had been missed. Staff were expected to document the date of the missed visit, the reason for the missed visit and the action taken. The reasons recorded for missed visits were basic, such as 'husband cancelled call', 'client cancelled call' and 'carers running late so client cancelled call', being the usual reasons given. The action taken column also contained basic detail, such as, 'Private client, no action required', 'spoke to case manager, reported to manager' and 'reported to case manager'. No further action was recorded as having been taken for any of the missed calls. One person was reported as having cancelled all their visits between 1 December 2016 and 27 December 2016. The reasons given were, 'client refused care due to not wanting the carer allocated', and 'reported to case manager' as the action taken. No further action was recorded as having been taken to address the person's concerns or to find a replacement staff member. We were told the person left the service following the cancelled visits.

Although the provider had asked people for their feedback this was through telephone questionnaires or staff asking people if they were happy with their care. Office staff rang people on 21 October 2016 to ask their views, recording their responses on a survey form. The provider completed an analysis of the ticked responses to questions asked. However, the analysis did not take account of the many negative comments that had been made by people and their relatives about late visits etc. There was no evidence of action taken to address the areas of concern raised in order to drive improvements to the service provided. People were not given the opportunity to give their views anonymously or to complete a questionnaire themselves or with a relative.

The provider did not have good financial systems in place to ensure that staff received their pay on time each month. Staff reported to us that there had been issues with their pay. Staff had received delayed and later payments in September, October, November 2016 and January 2017. Staff received letters each time this happened detailing that they would receive their pay in instalments. This meant that they had difficulty paying their bills. Some staff had left the service because of this.

The provider had failed to ensure that systems and processes were in place to adequately monitor and improve the service. The provider had failed to ensure that records were complete and accurate and failed to evaluate their practice. This was a breach of Regulation 17 (1)(2)(a)(b)(c)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries and deaths. The provider had not notified CQC about important events such as deaths, serious injuries and safeguarding concerns that had occurred. We spoke with provider about this and they agreed that they had not notified CQC of events. They told us they thought that the local authority informed us of safeguarding incidents.

Failure to notify CQC of these events is a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

The provider had not displayed the rating of the last inspection on their website, which is where most people, relatives and professionals would look when trying to find a care provider that provides care in

people's own homes. The provider had however displayed their rating in the office.

Failure to display the rating is a breach of Regulation 20(A)(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had invested in a new electronic care planning system. The system would be used by all staff using mobile phone and GPS technology in order to record all tasks carried out within people's homes. Although office staff were uploading all information onto the new system and the provider hoped it would be rolled out in the near future, it was not yet available for the benefit of people, relatives and staff.

Staff meetings took place on a monthly basis. Staff received a monthly newsletter from the provider which gave them information about important events such as new systems coming, training sessions, reminders about pay, confidentiality and report writing. Newsletters evidenced that staff were told they needed to spend the full allotted time in each care call.

Staff gave mixed views about the leadership of the organisation and the support they received. Most staff said they thought the registered provider was a very nice person who tried their best and had been working hard. Most staff also said the provider helped staff out when they needed it. The provider drove around non drivers to ensure they got to their visits if they were short staffed and a driver couldn't help. Other staff were critical of this as they felt there were too many non-drivers which placed a reliance on the drivers. Most staff felt very let down by the consistent non-payment of their salary on time and it was clear a lot of staff had left for this reason.

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 The provider had not notified CQC about important events such as deaths, serious injuries, events that affect the running of the service and safeguarding events that had occurred. Regulation 18 (1)(2)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to provide care and treatment with the consent of the relevant person. Regulation 11 (1)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to carry out adequate employment checks. Regulation 19 (2)(a)(3)(a)

Regulated activity	Regulation
Personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had not displayed the rating of the last inspection on their website so that people, visitors and relatives could view the rating

given by CQC following the previous inspection.

Regulation 20(A)(1)(2)