Ark Home Healthcare Limited

Ark Home Healthcare Halifax

Inspection report

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21 September 2017
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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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We inspected Ark Home Healthcare Halifax on 21, 22, 25, 26, 27 and 28 September 2017. We gave the provider short notice of our intention to inspect the service. This is in line with our current methodology for inspecting domiciliary care agencies to make sure the registered manager can be available. This was the first inspection of the service since the provider registered with the Care Quality Commission in May 2017.

Ark Home Healthcare Halifax is a domiciliary care agency which provides care and support services to people in their own homes. At the time of our inspection the service was providing support to 130 people in Calderdale, Kirklees and Wakefield.

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

In the three months prior to this inspection we received several concerns from relatives and staff about the care being provided to people. These related to people's care needs not being met, poor medicine management, late and missed calls, poor communication, the attitude of some staff and the lack of training. As a result we made safeguarding referrals to the local authority and brought forward the inspection so we could assess the overall quality of the service and check the provider was meeting the legal requirements.

We found medicines were not managed safely as records were incomplete so we could not be assured people had received their medicines when they needed them.

We found there were not enough staff to meet people's needs. Staff arrived late to people's homes and did not stay for the allocated time.

Safeguarding incidents were not always recognised or dealt with appropriately. We saw some incidents had been investigated and referred to the local authority safeguarding team, however we found two incidents that had not been appropriately reported. Safeguarding referrals were made following the inspection.

There were inconsistencies in how risks to people were managed. We saw some records provided detailed information which showed how risks were assessed and mitigated, yet other risk assessments contained very little information.

Recruitment systems showed criminal record checks and references were obtained before employment commenced, although gaps in employment had not been explored. Systems were in place to provide new staff with induction and shadowing experience. Essential staff training in areas such as moving and handling was kept up to date, however, staff raised concerns about the lack of specialist training in areas such as

continence care. We saw a range of specialist training was available from the provider, however, the regional manager confirmed none of the staff at the service had been provided with this training.

People's nutritional needs were met and they had were supported and enabled to access healthcare support as and when needed.The registered manager and staff understood their responsibilities under the Mental Capacity Act 2005.

People and relatives gave mixed feedback about staff. They spoke positively about their regular care staff who they said knew them well and were kind and caring. However concerns were raised about the attitude and manner of other staff, including the office staff. People told us they were not always treated with respect or listened to and their choices were not always respected.

People's care records were not always accurate or up-to-date and did not reflect people's needs or preferences. Complaints were not investigated in accordance with the provider's own complaints procedure.

We found there was a lack of consistent and effective management and leadership which coupled with ineffective quality assurance systems meant issues were not identified or resolved. Following the inspection the provider took immediate action and provided additional resources and senior management support to the service to make improvements. They also agreed voluntarily not to take on any new care packages until further notice.

We found shortfalls in the care and service provided to people. We identified seven breaches in regulations – staffing, safe care and treatment, safeguarding, dignity and respect, person-centred care, complaints and good governance. The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. 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 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.

Medicines management was unsafe as we could not determine if people were receiving their medicines as prescribed.

Staff recruitment processes helped ensure staff were suitable to work in the care service. Insufficient staffing levels meant people did not always receive their calls on time or for the correct duration.

Safeguarding incidents were not always recognised, dealt with or reported appropriately. Risks to people's health, safety and welfare were not always assessed and mitigated.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not always received the training and support they required for their job role and to meet people's needs.

People's rights were protected because the registered manager and staff understood their responsibilities under the Mental Capacity Act 2005.

People received support to ensure their healthcare and nutritional needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were not consistently kind and caring.

People's privacy and dignity was not always respected and maintained by staff.

Is the service responsive?

Inadequate

The service was not responsive.

People's support plans were not always person-centred and did not consistently reflect people's needs and preferences.

Complaints were not always listened to or dealt with effectively.

Is the service well-led?

Inadequate

The service was not well-led.

Leadership and management of the service was not effective.

Quality assurance systems were not effective in assessing, monitoring and improving the quality of the service.

Ark Home Healthcare Halifax

Detailed findings

Background to this inspection

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

The inspection was carried out on 21, 22, 25, 26, 27 and 28 September 2017. The inspection was announced. The provider was given notice because the location provides a domiciliary care service and we needed to be sure that the registered manager was available. The inspection was carried out by three inspectors, an inspector assistant, a specialist professional advisor in governance and an expert by experience. Three inspectors visited the agency office on 21 September 2017. Two of these inspectors and a specialist advisor visited the office again on 27 September 2017. The inspector assistant and expert by experience made phone calls to people who used the service and relatives.

Before the inspection we reviewed the information we held about the service. This included looking at information we had received about the service and statutory notifications the registered manager had sent us. We also contacted the local authority contracts and safeguarding teams.

We asked the provider to complete 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. The provider returned the PIR and we took this into account when we made judgements in this report.

During our visits to the agency office on 21 and 27 September 2017 we spoke with the registered manager, the regional manager, an apprentice administrator, three care workers, a training officer and three care co-ordinators. We looked at the care records of 14 people who used the service, six staff recruitment files, training records and other records relating to the day to day running of the service.

On 22, 25, 26 and 28 September 2017 we spoke on the telephone with 17 people who used the service and/or their relatives. We also spoke with eight care staff.

Inadequate

Is the service safe?

Our findings

The majority of people we spoke with either administered their own medicines or had relatives who assisted them with their medicines. People whose medicines were administered by the agency staff raised no concerns. However, we found medicines were not managed safely. Two staff told us of two different occasions when people had no medicine administration records (MARs) in their homes. They said they contacted the office and were told by the registered manager to administer the medicines anyway.

The MARs we reviewed were poorly completed. There were gaps on the MARs where there were no staff signatures to show medicines had been administered. This placed people at risk of harm as we could not be assured people were receiving their medicines as prescribed. One person's MAR for August 2017 showed they were prescribed ear drops to be administered twice a day. Over the 16 days these drops were administered there were 12 occasions where no entry or signature had been made on the MAR. Another person's MAR for August 2017 recorded one medicine had been 'not available/missing' for five days, another medicine for three days and a third for two days. When we asked the registered manager about this they were not able to provide an explanation.

For some people there was no information to show the medicines which were being administered. For example, one person's support plan showed staff administered medicines twice a day. The MAR for July and August 2017 stated 'dossett', which was signed as given three times a day. There was no information in the person's care records or with the MAR to show what medicines were contained in the dossette box.

Daily records showed staff were applying topical creams to some people however it was not always clear what creams had been prescribed or when they had to be administered. One person's support plan showed staff applied a prescribed cream on each call and daily records showed this was happening, yet there were no MARs in place to record this administration. Another person's needs assessment stated staff did not assist the person with their medicines, yet we saw from the daily notes staff were applying daily creams. There were no MARs for this administration. A further person's MAR stated they required a cream to be applied twice daily, however, we saw from the MAR and daily records this was not happening. For example, there was no entry on 2, 4, 5 August 2017. On 18 August a worker had recorded that the cream had been 'missed a number of night calls'. The cream they referred to was not included in the person's support plan.

Where people were prescribed 'as required' medicines, there was no guidance for staff about when to give these medicines or the required time gap between doses. For example, we saw MARs which showed people were prescribed pain relief medicine to be given up to four times a day. Where this was a variable dose staff were not recording whether one or two tablets had been given. The time of administration was not recorded which meant we could not determine if sufficient time had elapsed between doses. We saw records which showed the MARs for July 2017 had been audited by office staff and missing signatures and gaps had been identified. However we saw the same issues were found in the MARs for August 2017 which showed they had not been addressed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of people and relatives we spoke with told us calls were often late and said staff did not stay the agreed length of the call. One relative said, "There have been several occasions where carers have arrived late and the office has not communicated this and I have had to contact the office myself to ask where carers are." Another relative told us about a recent call when staff were supposed to attend at 10.45am and did not arrive until 12.30pm. They had not been notified by the office and when the care staff arrived they said they were late because they were 'very busy covering sickness'. People described staff rushing their care and not staying the agreed length of time for the call. Comments included; "They go as soon as they are done, usually one hour for the one and half hour morning call and stay only 15 minutes for the 40 minute lunch time call" and "The morning visit is very good but the evening visits are rushed – last night the carer stayed five minutes for a half hour call." One relative described how staff left after approximately 10 minutes when their relative was supposed to have a 30 minute call. The service operates an electronic call monitoring system and spot checks we made of recorded call times confirmed late calls and staff not staying the full duration.

Staff we spoke with told us the staffing arrangements were inadequate. They said, "Rotas are changed at short notice. I used to do a set run but this has been changed. The staff turnover is so high; seven more staff are leaving in the next few weeks. Calls are not spaced out enough." Another staff member said, "There's a lot of staff turnover and more are going. Runs have been changed in the last few weeks. They're cramming the calls in, taking our travel time off, we have to cut the time we're in with people to get everything done. It's not right." Staff told us on call arrangements were not satisfactory as often the staff member on call was out covering care calls and therefore could not respond or assist them. We saw this impacted on the service people received. For example, one person told us staff had not arrived for their morning call so 90 minutes after staff were due to attend the person contacted office staff who told them the care worker had slept in. The office staff member told us this missed call had not been picked up by the staff member on call as they had been out covering care. The office staff member told us this incident had not been recorded as a missed call but as a cancelled call. When we asked why they said because they had offered to go out and do the call when the person phoned in but the person had said no. We found this was a mis-representation of the facts as the call had clearly been missed.

The registered manager told us there had been a high turnover of staff since the service registered in May 2017 and they were currently recruiting for care worker, team leader and co-ordinator posts. We concluded from our discussions with people, relatives and staff there were not enough staff deployed to sufficiently cover people's care and support needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Extra staff were brought in by the provider after feedback we gave on the first day of the inspection. Further resources were provided following our second visit to the agency office.

A safeguarding policy was in place and we saw staff had received training in safeguarding adults. Records we reviewed showed many safeguarding incidents which had been reported to the local authority safeguarding teams and notified to CQC. However, we found other incidents of alleged abuse had not been reported or dealt with appropriately. For example, one person reported their swollen wrist had been caused by a care worker, this had been reported to office staff by another care worker but no action had been taken and the incident had not been referred to safeguarding. Some people and relatives also reported some staff were rough with them. Staff we spoke with told us they had reported concerns about some staff practices but nothing had been done. When we asked one staff member if they thought people were safe they said, "No, not really. I don't feel they are safe. They have missed medication, one person left in their bed high up and they could have fallen out. I have reported it all and nothing has been done about it." Following the inspection we made a number of safeguarding referrals. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found inconsistencies in risk management. We saw some risk assessments had been well completed, however we found examples where risk was not identified or managed. One person's moving and handling assessment stated they required hoisting however, there was no guidance about how staff should do this and the support plan just stated, 'hoist me'. Another person's care records showed they were prone to developing pressure ulcers. There was no information about how this risk was being managed. A pressure ulcer risk assessment had not been completed. On the second day at the agency office the registered manager showed us risk assessments which had been re-written and updated since our first visit. However, we found risk was still not being appropriately assessed and managed. For example, one person had a urinary catheter fitted but there was no reference to this in the continence section of the risk assessment. They were also at risk of pressure ulcers but there was no information to show how this was being managed. The registered manager told us where there was any indication of heightened risk people would have a specific assessment such as 'falls' and 'pressure sores'. We saw these were not being used consistently. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw examples where environmental risks had been assessed and this included areas such slip and trip hazards. One person's assessment identified a risk because when the microwave was in use a wire trailed in the kitchen; advice was given to unplug the microwave after use.

Staff files we reviewed showed recruitment checks had been carried out before new staff started employment. We saw evidence of criminal record checks with the disclosure and barring service (DBS) and two references. We saw there were employment gaps on some of the application forms and there was no evidence to show these had been explored. The provider had carried out an audit of staff files and identified some shortfalls which they were taking action to address.

Requires Improvement

Is the service effective?

Our findings

People using the service and relatives told us they felt their regular care staff were well trained and knew what they were doing. However, they shared concerns about the skills and abilities of other staff. One relative told us they felt staff did not receive enough training and shadowing shifts for new staff were 'not sufficient'. They were concerned some of the care staff were not experienced enough to be caring for their relative's complex needs. Another relative said, "New ones (staff) have to come and ask me what to do because they haven't read (relative's) care plan. I ask them to read (relative's) care plan but they just read the daily log."

The registered manager told us new staff completed a four day induction programme and a period of shadowing before working unsupervised. This was confirmed by staff we spoke with who had been recently employed. One staff member said, "I think the induction and shadowing I had prepared me well. I was asked if I'd had enough shadowing and could have had more if I'd wanted."

The care certificate was in place for new care staff. The care certificate is an identified set of standards that health and social care workers adhere to in their daily working life. The registered manager told us new care workers completed the care certificate, which comprised of the four day induction programme and five workbooks. The registered manager said they were responsible for undertaking a direct observation, spot check, medication competency and a supervision prior to the trainer validating the care worker's evidence for completion of the Care Certificate. The registered manager told us four staff were undertaking the Care Certificate. However, three staff files we reviewed provided no evidence to show the workbooks or care certificate had been completed. For example, one staff member's file showed they had completed the provider's induction training. They had no previous care experience and should have completed the care certificate, yet there was no evidence of this. We saw a record of shifts where they had shadowed a care worker on 17, 18 and 19 July 2017. The forms were incomplete and had not been signed by the care worker providing the shadowing.

We received mixed feedback from staff about training. Some told us they thought the training was good, however others raised concerns about the lack of specialist training. One staff member said, "People are catheterised and we haven't had training. I registered an interest to do dementia training but never heard anything. I also have expressed an interest to do training through the Ark app but have not heard anything even though I've applied through the app, rang and left a message." The registered manager showed us the electronic training matrix which was colour coded to show when training was due. This showed the majority of staff had received training in areas the provider deemed mandatory such as moving and handling and safeguarding. The regional manager showed us a catalogue of specialist training available to staff which was launched on 6 March 2017. However they stated none of the staff had undertaken this additional training.

Staff also had mixed views about the support they received. Some said they were well supported whereas others felt they got very little support. For example, one staff member said, "I've had spot checks and supervision every three months." Another staff member who had worked at the service for a year said, "I've had no spot checks and only one supervision." The registered manager showed us the matrix which

identified when staff supervisions and appraisals were due. However, the matrix was not up-to-date and showed appraisals and supervisions were overdue. We concluded staff were not always provided with the training and support required for their roles. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

We found evidence in some people's care records which showed they had been consulted about aspects of their care. However, for other people there were no records to show consent had been obtained or mental capacity assessments recorded for people who may lack capacity in making certain decisions. On the second day of the inspection the registered manager told us they had started reviewing and updating people's care records which included capacity assessments and obtaining and recording consent.

We found inconsistencies in the information provided about people's dietary requirements. For example, we saw one person's support plan provided information about the soft diet and thickened fluids they required, as well as the assistance they required from staff with their meals and drinks. However, other people's care records provided little information about dietary needs.

Electronic records we reviewed showed healthcare professionals had been contacted by staff when concerns were raised about people's health and well-being. For example, a social worker had been contacted because one person had insufficient money to purchase provisions, a GP was contacted because staff were concerned a person might have an infection and a social worker was contacted with a request to hold an urgent review. Where health professionals had contacted the service this was also recorded. For example, a district nurse had shared information about symptoms a person may experience and a social worker had provided an update about a person's visits.

Requires Improvement

Is the service caring?

Our findings

The majority of people and relatives we spoke with raised concerns about the service, although they praised the regular care staff who visited them. People and relatives said the regular care staff knew them well and described them as 'very good', 'superb', and 'absolutely fine'. One person said about their regular carer, "I am extremely happy with (name), she is never late and never in a rush, always takes her time." This person told us they were concerned about what they would do if this care staff member left, as before they had this care worker they had problems with care staff arriving late and missed calls. A relative told us they were 'delighted' with a care worker who they said, "Works for (my relative) and not just for a pay packet, she really cares." Another relative described one of the care staff as a 'shining light' and an 'exceptional carer'.

However, many people and relatives we spoke with also raised concerns about the staff. One relative said, "Staff generally have a bad attitude and only one or two actually care about my (relative). I am unhappy overall with the standard of care (relative) is receiving. Weekends are the worst." Another relative said, "The staff we are used to and that (relative) liked are all leaving and new carers are attending who we don't know, it's very upsetting, I hate it. It is causing (relative) distress because (relative) likes to get used to staff." A further relative told us they were very unhappy as the staff who knew their relative attended less frequently now due to rota changes and new staff did not know their relative's needs. Another relative said, "Some of the attitude of the staff is clearly one of couldn't care less. They complain to my (relative) they have too much work to do. For example, I have 34 people to see to today."

We found there was an inconsistent approach to people's choices and preferences, which were not always respected. For example, we saw one person's cultural needs were met as their preference for female staff was respected and rotas showed only females attended their calls. We saw a list of Punjabi speaking female care staff were identified as a first preference.

However, other people and relatives told us they had specifically asked for female care staff to attend their calls and said their preferences were disregarded even when they had raised concerns with the registered manager and office staff. One person told us they required two staff at each call and during the week they had regular female care staff. However, at weekends and when their regular staff were on holiday, a male staff member attended with the female staff member. They said the male staff member stayed downstairs while the female worker attended to the person's needs alone although there should be two staff providing this support. The male staff member then came up to assist transferring the person in the hoist. The person said they found this extremely uncomfortable and, "I feel like my dignity is not being respected." This person told us they had raised their concerns with the registered manager and was told, "It's either this or you stay in bed." Staff also told us they had passed on concerns, raised by people about male care staff attending them, to office staff and nothing had been done about it.

People and relatives told us they were not always treated with respect by staff. One person said, "I have raised my concerns with the office a few times but they just ignore me and are short with me. I feel like they just think I'm moaning at them. The manager has also been rude to me on one occasion." Another person said, "I have often left messages (with office staff) which haven't been passed on or been ignored. I've had to

chase a few times so communication isn't very good." A further person said, "Carers are pretty good – it's the office staff who have a negative attitude." This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

People and relatives we spoke with raised concerns about the care and support provided. One relative told us they were not happy with some of the care their relative received and said, "It is a sigh of relief when the carers leave. They don't wash him properly or use enough soap and water. I have to watch them doing it. They're also a bit rough with him at times. But generally they're okay." One person told us they had not had a bath or their hair washed for three weeks.

Staff we spoke with also shared their concerns about some of the care provided to people. For example, people's continence needs not being met as continence pads and catheter bags were not changed, people's hygiene needs not being met as people were not receiving baths or having their hair washed. Staff told us some of the people they visited did not have care plans in place.

The registered manager told us before a service began a team leader visited the person and carried out an assessment of their needs. Support plans and risk assessments were then completed and copies were kept in the person's home and in the office. On the first day of the inspection the registered manager was unable to locate three of the care files we requested and had to send staff to retrieve these files from people's homes. One of these people was in hospital so the file could not be accessed. The registered manager told us they had commenced an audit of people's care files three months ago but they did not know which people had care files or which ones were missing. They were aware some copies of care plans were not available in the office and some people did not have files in their home. The registered manager told us the care files contained care plan audits. However, we did not see audits in any of the care files we reviewed.

We found significant variation in the quality and detail of the care records we reviewed. For example, one person's support plan contained some person centred information such as 'porridge to be soft and creamy', 'cup of tea with two sugars', 'please ensure I am wearing my care link pendant' and 'I only have a small appetite so sometimes I will only like to eat a third of a ready meal'. However, we saw other information was not specific and did not provide adequate information about how care should be delivered. For example, 'please assist me with a strip wash or a shower'; there was no guidance about how staff should support the person. Another person's support plan and risk assessments were dated November 2015 and did not reflect their current needs. For example, the assessment showed they had one call a day, yet when we checked with office staff the person received two calls a day. Although a quality review in May 2017 had identified the care plan needed updating this had not been addressed. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of the inspection the registered manager told us additional resources had been brought in and all the care plans were being reviewed and updated. They said team leaders were going out to visit people in their homes to carry out the reviews.

People, relatives and staff expressed a lack of confidence in the complaints procedure. People and relatives told us they had raised concerns but many felt they had not been listened to and the issues they had raised had not been addressed. Comments included: "I was not taken seriously when I complained and there was

nothing done about it" and "I have raised my concerns with the office a few times but they just ignore me and are short with me. I feel like they just think I am moaning at them." One relative told us of a recent meeting they had had with the registered manager where they had raised concerns about aspects of their relative's care. There was no record of this meeting, the concerns raised or the action taken in response.

We looked at the complaints file which showed seven complaints had been recorded since the service was registered in May 2017. We saw appropriate action had been taken in relation to six of these complaints. However, for one complaint there was no detail of the action taken in response to the complaint. The registered manager told us, "I can't find anything to support this. I know I spoke to [name of person] and they did not want to pursue it. This has not been done this needs to be completed."

We spoke to staff about the complaints procedure. Several told us they had complained before and nothing had been done about it. One staff member told us, "Nothing gets done so I don't bother now." Another staff member said, "I have reported things to on call and the registered manager and nothing has been done about it."

The registered manager told us if people raised concerns they were asked if they wanted to make it 'formal' and if they did then this was logged as a complaint and taken through the complaints process. They said if the person did not want to make it 'formal' then the issue was logged as a concern on the electronic system and the action taken in response recorded. However, we found this did not correspond with the provider's complaints procedure which defined a formal complaint as, 'An expression of dissatisfaction with a service provided by Ark Home Healthcare Ltd that cannot be resolved initially and that requires an investigation to respond'. We concluded complaints were not always investigated thoroughly and necessary action had not always been taken where failures had been identified. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager who started in post in March 2017. Many of the people and relatives we spoke with raised concerns about the management of the service and in particular communication. Comments included: "There has been such a shake-up of managers that it seems like it has now become more about convenience than what I want. It is really upsetting because this is my life and all these changes feel so unnecessary" and "I'm very unhappy with the office staff and the lack of communication with service users and their carers, they don't communicate what's happening." One person said about the office staff, "They could be better trained and improve communication. I have often left messages which haven't been passed on or been ignored. I've had to chase a few times so communication isn't very good."

Although a small number of staff said they were happy with the way the service was managed, many staff raised concerns about the management which included a lack of support. They told us communication was poor and important information was not passed on. One staff member told us, "I love working for clients but not Ark. There is no communication from the registered manager or the office staff." Another staff member said, "There's no support, we (care workers) just have to support each other. We're not valued or listened to. You don't know who you can trust in the office." Two staff told us they worked in a bullying culture and provided examples where they had their rotas changed because they had either had time off work or raised concerns with the management team. They said they had tried to raise concerns with the regional manager but had not had a response. Several staff raised concerns about the support they received outside of the usual office hours. One staff member said, "We don't get a response from on call. Often they are out doing calls. They are not supportive and don't provide assistance." A member of the management team confirmed this and said they often had to cover calls when they were responsible for on-call so could not provide appropriate support.

On the first day of the inspection the registered manager showed us a quality assessment audit report completed by the organisation's quality and compliance manager on 13 June 2017. This identified several areas for improvement. On our second visit to the office the registered manager showed us the action plan they had put in place to make the improvements. We found the plan was incomplete as some of the improvements had no actions or timescales for completion or name the person responsible for making the improvement. This included areas such as recruitment, staff training and safeguarding. We also found limited progress had been made with other actions such as auditing care records and medicine administration records (MARs) and updating customer risk assessments.

Limited quality assurance systems were in place to assess and monitor the quality of service people received, together with systems to identify where action should be taken. For example, the registered manager told us the team leaders audited all of the MARs and communication logs on a monthly basis. The registered manager said they sampled 10%. They said some of the MARs and communication logs had been audited but others were "still in boxes" and they needed to go through these and update the system. The registered manager provided us with a report which indicated 29% of the MARs and 5% of the communication logs had been audited. When we asked the registered manager what were the main development areas for the MARs, they told us, "Not completing them properly, MAR sheets missing and not

signing for creams." In relation to communication logs the main development areas were, "Missing start/end times, the date, not writing what has been completed, the circling."

The registered manager said the regional manager visited two to three times per week to offer support with care plans, staff files, complaints and safeguarding. When we asked for a copy of the provider visit reports we were told there was no record of the visits to check the quality of the service and no identification of shortfalls or detailed action plans for areas identified for improvement. The only record we saw was related to a 'branch monitoring visit' in April 2017 which was prior to the service being registered with the Care Quality Commission.

The registered manager told they reviewed the complaints folder on a monthly basis. The electronic record system showed 17 complaints had been recorded between 13 June 17 and 27 September 2017. The nature of the complaints were around safeguarding incidents, missed visits, medication, care worker's attitude and the standard of service/care delivery. However, the complaints log was not up-to-date with the review date, sign off and outcome information, which meant that progress could not be accurately monitored and we could not be assured that complaints were satisfactorily handled in a timely way. The electronic log did not reflect the paper records we reviewed which showed only seven complaints had been received since May 2017.The registered manager told us complaints were shared with staff within scheduled team meetings and via supervisions. This meant there was a limited system in place to gather people's complaints and we could not be assured people's complaints had been acted upon and responded to in a way which resolved the concern, in addition to minimising the risk of the same issue arising in the future.

The registered manager told us there had only been one accident which we saw recorded in the accident book. However, there were no accidents recorded on the electronic system. This showed there was a limited system was in place to monitor incident systems and the service may not learn from incidents, to protect people from harm and indicated that there may not be a commitment to continuously improving practice in the service.

The registered manager told us quality reviews were carried out with people who used the service every three months by a home visit or telephone call. They provided us with a report which showed 32% of these reviews had been completed. However, we found no evidence to show that issues raised during these reviews had been resolved. For example, we saw one person's quality review dated 7 May 2017 stated information provided about the service was poor, their care plan had not been updated, they were not informed if staff were going to be late and specific concerns were raised about the attitude of one staff member. We saw their care plan was dated 24 November 2015 and there was no evidence to show what action had been taken in response to the other issues raised.

In conclusion we found there was a lack of effective leadership and management which impacted on the progress made in driving forward improvements. Governance systems were not effective as issues identified through quality audits had not been addressed. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the provider took immediate action to provide additional resources and senior management support to the service to enable improvements to be made.