Cera Homecare Limited

Manchester Services Limited

Inspection report

160 City View House
5 Union Street
Manchester
M12 4JD

Date of inspection visit:
20 September 2022
29 September 2022

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22 November 2022

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

About the service
Manchester Services Limited (also known as CRG and Cera Manchester) is a domiciliary care service providing personal care to people living in their own homes. The service provides support to older people, people living with dementia, learning disabilities and autistic spectrum disorder, mental health, physical disability and sensory impairment. At the time of our inspection there were 214 people using the service.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
The poor planning of visit times impacted on people's health and wellbeing and put people at risk of the unsafe management of medicines, skin integrity and nutritional care. There was a lack of consistency in staffing and the provider relied on agency workers who did not receive an induction to the service. Missed visits were a regular occurrence.

People did not receive the commissioned times of care and support. Staff told us they didn't have time to stay for the entire visit and there was not enough travel time. Staff said they would often find their rota changed and have to travel long distances or get taxis to try and reduce the impact on people's visiting times.

There was a lack of oversight from the provider and governance arrangements were not clear. There was a lack of understanding about risks and issues across the service. Concerns and complaints were not always responded to and staff did not feel supported or have the direction they needed to support people appropriately. Staff were not receiving regular supervision and competency checks.

Staff did not always have access to information to enable them to effectively support people. People were not able to review their care plans and some people did not feel involved in planning their care. People were not always informed which staff members would be visiting them and choice of carer gender was not always respected.

People did not know the name of the agency supporting them due to merging with other agencies and subsequent name changes. Staff were confused of what processes they were following due to the number of changes and differing paperwork and policies being in use.

People didn't always feel they were treated with kindness and respect and there was a lack of a dignified response from the office staff. Communication across the service was lacking and it was evident from speaking with people and their relatives, the lack of communication was causing distress.

People were not supported to have maximum choice and control of their lives. Care records were not clear in relation to how people who lacked capacity were consenting to care and treatment; the policies and systems in the service did not support this practice.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

At the time of the inspection, the location did not care or support for anyone with a learning disability or an autistic person. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it is registered as a specialist service for this population group.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
This service was registered with us on 28 September 2021 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about staffing and the timeliness of visits to people to deliver personal care and support. A decision was made for us to inspect and examine those risks.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to person centred care, safe care and treatment, good governance and staffing at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement

procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Manchester Services Limited

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection team consisted of three inspectors and three Experts by Experience conducted phone calls to people and relatives who use the service.

An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A manager had commenced employment at the service, two weeks prior to our inspection and was intending on registering with the Care Quality Commission.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 20 September 2022 and ended on 29 September 2022. We visited the location's office on 20 September 2022.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
During the inspection we spoke with the area manager, the service manager, two quality improvement leads and two coordinators. We emailed 91 staff members with a questionnaire and received nine responses. We also spoke with five staff members by telephone. We spoke to 36 people and their relatives via telephone about the care they received.

We reviewed multiple documents in relation to care planning including visiting logs. We reviewed medication records, staff supervisions, appraisal, competency and spot checks. Recruitment, training and safeguarding records. We requested a number of documents for auditing and oversight of the service which we did not receive.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

● The provider did not ensure staff had the time to give people the care and support they needed. Changes to the staff rota at short notice or without notice were often made and people did not receive their care and support at safe and timely intervals. Staff told us they often did not know who they would be supporting as their rota was changed daily and they were not always informed.

● Of the 36 people and relatives we spoke with, 18 of those people had recurrent very early or very late visits from staff members which impacted on their personal care, wellbeing and medication arrangements.

● Seven of those spoken with, told us they recently had some of their visits missed with no contact from the office and they were not receiving care and support from a consistent staff team. This was confirmed when we reviewed visits logs for each person.

● People and their relatives spoke overwhelmingly with the dissatisfaction they felt about Manchester Services Limited and comments included, "No carers turned up today and yesterday. They promise to get back to me, but often no one does." and, "This company is terrible, sometimes they don't show up until a couple of hours late. They send people who haven't been before. Some don't have a uniform." and, "Some (carers) don't come and as a result, I didn't get my medication until the afternoon."

●Agency staff were regularly used. People and relatives told us, many of the agency staff don't know what they are doing and there is sometimes a language barrier. Agency workers were not always provided with a phone or had access to care plans.

● The majority of staff we corresponded with told us there was no organisation to the rota. Staff told us, they were not informed their rota had changed which led to late and missed calls and they often would ring the office out of hours and not always receive a response. Comments from staff included, "No one knows what they are working." and, "There is no organisation. They move staff around. You can wake up in a morning and all your calls have changed and no one tells you." and, "A second carer has not shown up a few times as their rota was changed, and they were not informed."

The provider did not deploy sufficient numbers of suitably competent staff to ensure they met people's care and treatment needs. This is a breach of regulation 18 (staffing) of the Health and Social care Act 2008 (Regulated Activities) 2014.

● The recruitment staff of was completed by the providers head office. We did find some examples of where the employees full job history was not fully explored, and references had been obtained from friends rather than previous employments or professional character references.

The provider did not ensure robust recruitment checks were in place for all new staff members. This is a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated

Activities) 2014

● New staff did have disclosure and barring service checks in place. This check helps providers make safer recruitment decisions.

Using medicines safely
● People did not always receive their medicines safely.
● There were multiple examples of where people did not receive their medicines as prescribed. This included where people were receiving pain relief too close together instead of four hourly intervals. Time specific medication such as for Parkinson's Disease, were not being administered as directed and a person was not always receiving medicines for the management of diabetes and no further action had been taken.
● Medication administration records were not always fully completed. We were not assured if this was because the calls were late, and staff did not have the time or because the medicines had not been administered.
● We were not assured, all staff who dispensed medicines had been competency checked as part of their training. Some staff told us they had never had a competency check but were listed on the matrix as receiving one. Other staff had a date noted for the competency check which pre-dated their employment start date.
● People and relatives were dissatisfied with the medicines support they received from the provider. Comments included. "Some (carers) haven't given medication before, so we have to tell them." and "I didn't get my morning medication until this afternoon."
● Some staff told us they were often worried about people who did not get their medication as required. Comments included. "This is very dangerous for the user because they might be medicine-sensitive and need service (medicine support) at the right time." and, "I worry people don't get their medicines or its rushed and the medicines are wrong."

The provider did not ensure medicines were safely administered following the prescriber's instructions. Medication records were not always accurately completed. This is a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not always safeguarded from the risk of abuse.
● The inadequate management of the web roster (a management system for managing home care visits) meant people were not receiving the assessed care and support when they needed it. We found multiple examples of where people had not been supported due to early, late or missed calls as per their care plan and this had not been reported to the local authority safeguarding team or to the Care Quality Commission.
● Staff had been provided with training to underpin their knowledge on safeguarding vulnerable adults, but many staff felt any concerns they had were shut down or not responded to. Staff gave examples of contacting the office to raise concerns and phones were not answered or they did not feel listened to.

The provider did not have robust systems and processes to enable them to identify where quality and safety are being compromised and did not respond without delay. This was a breach of regualtion17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014

Assessing risk, safety monitoring and management
● Although people did have risk assessments in place, in part, they were ineffective as staff were not staying for the duration of the call to ensure risks were managed safely and effectively.
● People who had risks in relation to skin integrity and nutrition were not always safely supported to

manage the risk. People and their relatives told us, they were not always given the wash or bathing they required and missed out on vital meals due to missed or wrongly timed visits. This put people at risk of skin breakdown and weight loss.

● Staff we spoke with felt unsafe, particularly when their visits ran later into the night as they were required to walk in some areas with high crime rates and no action had been taken by the provider to assess this risk.

● Staff told us, they were often told they needed to visit a new person and didn't always have access to the person's information and were not always aware of the risks the person presented or how they should care for them.

The provider did not do all that was reasonably practical to mitigate risk and they did not adopt control measures and review measures to ensure each risk was as low as possible. The provider did not always ensure the safety of staff. This was a breach of regulation 12 (safe care and treatment) of the Health and Social care Act 2008 (Regulated Activities) 2014

Learning lessons when things go wrong

● Accidents and incidents were recorded and there was some analysis of incidents to prevent future occurrences. However, safety concerns were not always identified quickly enough, for medication management and the management of risks.

● Staff told us they would report any accidents and incidents to the office or in an emergency, they would contact emergency services.

Preventing and controlling infection

● People told us staff mostly wore personal protective equipment (PPE) such as face masks and gloves. Some people commented some staff wore an alternative mask to the type 2 surgical face mask as advised in infection control guidance.

● Staff told us they had access to PPE and were aware of the most up to date information in relation to the COVID-19 pandemic.

● People and relatives told us staff were generally following good hygiene but there were times when some staff did not always wash their hands between tasks

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff did not always receive the training to enable them to complete their job role effectively. Staff did not always have the correct knowledge and competence or have the skills to support people in their own homes. Staff were not clear about their role.
- The provider had a training matrix in place which was not up to date. Staff TUPED (transfer of undertakings protection of employment) over from other care agencies did not have an up to date list of training and we were not assured training had been provided to all staff. We received mixed comments from staff about training including, "It was e-learning only." and "Training is rushed." Some staff had not received any further training since they commenced employment with the provider.
- We saw spots checks were undertaken and a record of these checks were kept in staff files. Many of the records were printed and had not been signed by the staff member. Some staff told us they had never received a spot check with one staff member telling us, "The checks are done over the phone, no one from the office actually visits you at the property."
- We received mixed responses from staff about the induction. One staff member told us; they had an induction but was not given the opportunity to shadow more senior staff. Another staff member told us, "I had two days training but then no contact afterwards for weeks. I got half a day's shadowing."
- Agency staff were being used to cover the shortfall in staff vacancies. Agencies workers did not receive an induction to the service and very often did not have a phone or identification badges.

The training, learning and supervision of staff members was not always carried out. Regular spot checks on staff members competence was not always carried out. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Supporting people to eat and drink enough to maintain a balanced diet

- People were not supported to eat and drink enough. Meal support was often rushed due to insufficient staffing.
- Care plans did state the support required for people to eat and drink, but it was evident people were not receiving the correct level of support. We received many complaints of early, late and missed visits which impacted on mealtimes and a relative told us, when the morning call was missed, this resulted in their relation going for many hours within adequate nutrition.
- A further relative told us, "Calls are four times a day but sometimes breakfast call can be as late as 11am." We reviewed the care records for this person and found the lunch time call could be an hour or two later and the relative told us with two calls in quick succession, their relation missed out on further nutrition as they were not hungry.

● Care records did not always clearly state what people had eaten and drank. Staff told us the time between visits was not enough which then impacted on the support people required to maintain a balanced diet.

The provider did not ensure they supported people's nutritional and hydration needs to support their wellbeing and quality of life. This was a breach of regulation 9 (person - centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were not supported to live a healthy life and were not supported positively to achieve best outcomes.
● Where people were not engaging in care such as not opening the door for care staff or refusing care and treatment, the provider did not make timely referrals to health and social care professionals for further review.
● A staff member told us when they needed to report concerns, "I'd speak to [care-coordinator] but I get the impression they are overworked, feels like a lot is weighted on their shoulders."
● People told us they did not always receive support with bathing and showering when they needed it. One person told us, "The staff don't even look in their book to see what they have to do for me. All they do is cream my legs and back and wash a few dishes in the sink, and they don't even do those things very well."

The provider did not make every reasonable effort to meet people's preferences. The provider did not ensure care and treatment was designed to ensure it met people's needs. This was a breach of regulation 9 (person - centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● People's capacity was not always assessed by the provider. It was not clear how people who lacked capacity were consenting to care and treatment as this was not recorded in the care records.
● The management of the service did not check or audit consent activity.
● Staff covered training in MCA as part of their induction.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider used assessments from the local authority to inform care plans and risk assessments. There

was some evidence in care plans, the provider completed their own assessment of people's needs in additional to the local authority care plan.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care: Respecting and promoting people's privacy, dignity and independence

● People were not always treated with dignity and respect or involved in making decisions about their care. Staff were sometimes focussed on the tasks needed to be completed rather than providing person-centred support due to time restraints. Preferred call times were not adhered to.
● There were some positive comments about staff and people and relative's felt staff were trying their best in difficult circumstances. The lack of a consistent staff team impacted on people's care and support and people's choice of gender of carer was not always respected.
● Some people and relatives felt the office staff were not always responsive to their calls of concern and felt their voices went unheard. Staff members told us the office staff don't always have oversight of where staff should be and when.
●Staff told us they did not always have the opportunity to get to know people and were often told at last minute, they were to support a new person and didn't have access to the information to enable them to provide support effectively. One staff member told us, "If we get a new client, they should contact me, and they don't. There is no time to understand people's needs." Another said, "If I go to a new client, I call the office as I want to know more about them. But very often, I wake up and all my calls have been changed. I worry the care is rushed and medicines are rushed and then medicines are wrong."
● People and their relatives told us, "Carers are kind, but I have complained they do rush. I ring the office and they just say they will pass it onto [names] carers but it doesn't change." and "They are caring people; I just wish it was the same staff all the time."
● Staff felt they were trying their best to deliver care but felt they were restricted due to travel times. Staff told us, "They give us five minutes gap between each call and it's very tight, even for a driver. It's much tighter for walkers. I use any spare time to get to the following [person]. We sometimes get sent on long routes."

The provider did not ensure they robustly planned how to meet people's preferences and did not take into account and make provision for any impact this may have on other people using the service. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

- People and relatives told us they had to repeatedly make concerns and complaints known to the provider about care and support. It was evident by talking to people and relatives, the provider had not engaged with people following complaints being made. We report on this further in the well led domain.
- Many of the concerns and complaints were about the poor timings of visits to people, missed visits and staffing. There was a log of complaints kept but we observed on the day of the office visit, there were many phone calls about the timeliness of calls, and these were not being logged as a concern or complaint.
- People and their relatives told us, "I've complained about things but it's like talking to a wall. They are the most chaotic company I've ever known," and "We have called at least three times to complain but it was not until our social worker intervened anything changed."
- One relative told us, they had phone the office on the day of our inspection as staff had not arrived to support their relation. On reviewing the care record, the visit had been documented as cancelled but the relatives stated this was not the case.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans were on electronic devices, and most staff accessed them via an app on a mobile phone. Some staff we spoke with did not always have access to a phone or the app which meant they were not always aware of people's needs.
- Three staff members told us they did not have access to a phone so could not access care plans and where staff did not have work mobile phones, they were required to download the app to their personal phone. It was not clear from the inspection how this information was kept confidential and we have asked the provider for further assurances.
- People and relatives told us they did not always feel involved in planning their care and often had to tell staff how to care for them. Comments included, "I don't actually know about the care plan or where it is."' and "I was involved in [names] plan. It was here in a paper form until last year when it changed on put on mobile phone.", and "I haven't been involved in a care plan."

The provider did not ensure the care plan was accessible to authorised people as necessary in order to deliver people's care and treatment in a way that meets their needs and keeps them safe. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the

Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The provider did not ensure they provided information to people in the most suitable format.
- People and relatives could not access information about their care as it was stored electronically.

The provider did not provide information in a way that the person understands. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

End of life care and support

- People could be supported at the end of their life by the provider.
- There was no one receiving end of life care at the time of the inspection.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;

- The provider did not understand quality performance. Systems for identifying and capturing organisational risks were ineffective.
- The provider was using a number of management systems across the service including care planning, the rostering of staff, recruitment, accidents and incidents and other reporting systems. On the first day of the inspection for one and a half hours, no systems could be accessed as people did not have access log ins, they were not trained or did not know how to access the systems. The provider was reliant on the service manager to come into office to enable the Care Quality Commission to obtain access. An office staff member told us, "Everything is on [service manager]. If it wasn't for them, the branch would crumble."
- We requested to review quality audits completed by the provider and were told they were completed by another team. We asked for these audits on a number of occasions and were not shared the information. We were told by an office staff member; audits were completed but they had no idea of the findings as they were not shared.
- Medicines audits could only be manually completed and although a report could be populated which showed where there were discrepancies with medicines, no further action was taken. Office staff told us there was no time to undertake quality checks or provide support to staff.
- During the visit, office staff were constantly fielding calls from people and their relatives about the timeliness of visits and missed visits. There was no process in place to record and respond to these concerns and we overheard one office staff member tell a caller, "We also look after other people who are in a much worse position than you."

The provider did not have systems and processes in place such as regular audits of the service to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The service was not well-led. There were no credible vision of values and people were not supported in a positive and person-centred way. Most staff did not feel supported in their role and did not feel listened to and respected.
- It was evident from our inspection; people were not at the centre of their care support. Call logs showed

people received much less than the allocated time for each visit. It was not possible to fully assess how much time each staff member spent at each property as staff members were logging in and out from the property at up to 2.5 kilometres away.

● People and relatives told us when staff did arrive, they were often very early or very late or they did not arrive at all. They also told us communication was severely lacking with many relatives telling us they have made numerous complaints with promises of "Putting things right", but which doesn't happen.

● We reviewed the key performance indicators for visit logs and found the provider had high compliance. This information was regularly shared with the local authority for monitoring purposes. When we crossed referenced this information with the actual visit logs, we found large discrepancies and the provider was not being honest and transparent about the timing of visits to people.

● People and relatives gave us many examples of when their calls to the office had gone unanswered or they did not receive any further contact. Comments included, "The office (staff) are fine to talk to on the phone although things do not change as a result of any calls we make.", and "Almost year ago, when I rang the office to complain, they told me to write it all down. The timings, the dates and the problems but no one is asking me what is going on. Even when they (staff) answer calls, they are just rude to me."

● The majority of staff felt they either raised concerns with office staff and it wasn't acted upon or felt discriminated against and knew if they raised ay concerns, they could potentially be victimised or bullied. Staff members told us they had been shouted at by management and had shifts taken away from them if they did not follow managements requests.

●Staff were unaware of information pertinent to their job role and feedback was not acted upon. One staff member told us they would ring the office as information about how to support people wasn't available on the app and very often the office staff would not know the information either.

● There were some examples of telephone feedback being obtained from people and their carers with the majority being negative feedback. There had been no action taken following this feedback being received.

● Most staff told us they were confused as to what processes they were following. There was a mixture of the previous providers paperwork and polices in place and staff told us they were not clear on what they should be following.

● People did not know the name of the agency was supporting them. Many name changes to the service caused confusion with the name changing twice since the inspection commenced.

The provider did not have effective communication systems to ensure that people who use the service and staff were supported in an open and inclusive environment. Feedback from people and was not acted upon. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014

Continuous learning and improving care

● The management did not understand the principles of good quality assurance and did not drive improvement.

● An undated action plan was provided to us during the inspection for area's for improvement. The plan did not incorporate any of the concerning findings from our inspection and there was no information in the action plan to support performance monitoring and ensure the plan is valid and up to date.

● There was a high turnover of staff and 117 employees had left the service within the last 12 months. The provider lacked any reflective practice regarding the turnover of staff, and we were told by staff throughout the inspection, they actively looking for new jobs and to leave the providers employment.

The provider failed to drive improvements without delay. This was a breach of regulation 17 of the Health and Social care Act 2008 (Regulated Activities) 2014.

Working in partnership with others

● There was little evidence of partnership working with other health and social care professionals.
● The provider had been supported by the local authority to improve following previous concerns being raised, about the timeliness of visits. However, it was evident throughout our inspection, this support had not been embedded into practices to improve the service for the vulnerable people they supported.