Compleat Care (UK) Limited

Homecare Helpline

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Homecare Helpline is a domiciliary care agency registered to provide personal care to older people, people living with dementia and people with a physical disability. About half of the people who use the service live independently in their own houses and flats in the community and about half live in three 'extra care' sheltered housing schemes in Grantham, Bourne and Sleaford, where people's care and housing are provided under separate contractual agreements.

We carried out our second full inspection of the service in June 2017. At this inspection we found the registered provider had not complied with a Warning Notice issued following a previous inspection and was in continuing breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA). This was because the registered provider had taken insufficient action to improve the organisation of staffing resources and the scheduling of people's care calls. At this inspection we also found three further breaches of regulations. This was because of shortfalls in organisational governance; a continuing failure to ensure people received safe and consistent support with their medicines and a continuing failure to ensure all staff had the training and supervision necessary to support people safely and effectively. We rated the service as Inadequate and placed it into Special Measures.

We conducted this third full inspection of the service between 20 March and 11 April 2018. The inspection was announced. The Care Quality Commission (CQC) does not regulate premises used for extra care housing. This inspection looked at people's personal care service. On the first day of our inspection, 163 people were receiving a personal care service from the provider.

At this inspection we found the provider was still failing to ensure the safe and effective organisation of staffing resources and scheduling of care calls for people living independently in the community. Almost two years after we had first highlighted significant shortfalls in this area, it was extremely disappointing to hear of people's continuing concerns about late and short care calls and a lack of staffing continuity.

Ongoing shortfalls in the management of the service meant some people were still not receiving the safe, well-led service they were entitled to expect. The provider was failing in its aspiration to deliver a high quality, person-centred service to people living independently in the community and remained in breach of legal requirements in relation to organisational governance and the organisation of staffing resources.

Improvement was also required in a number of other areas including the management of people's medicines; infection prevention and control; care planning; adherence to good practice and legislative guidance; complaints management; team working; nutritional support and communication from office based staff.

The overall rating for this service remains Inadequate and the service remains in Special Measures.

We are currently taking action against the provider to ensure that they make the necessary improvements to

become compliant with legal requirements. 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.

In some areas the provider was meeting people's needs effectively.

People living in the extra care housing services were very satisfied with the quality of service they received from the provider.

The provider provided staff with training and supervision appropriate to their needs and was no longer in breach of legal requirements in this area. Staff knew how to recognise and report any concerns to keep people safe from harm and the provider assessed potential risks to people and put preventive measures in place. Staff worked alongside local healthcare services where necessary.

Individual members of the care staff team were kind and considerate in their approach. Care staff promoted people's dignity and privacy and encouraged people to have choice and control over their lives. CQC is required by law to monitor how a provider applies the Mental Capacity Act 2005 (MCA) and to report on what we find. Staff understood the principles of the MCA and reflected this in their practice.

There was no registered manager in post at the time of our inspection. However, the new manager appointed by the provider in November 2017 had submitted an application to become the registered manager and was waiting for this to be assessed by CQC. A registered manager is a person who has registered with CQC to manage the service. Like registered providers ('the provider'), they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the HSCA and associated Regulations about how the service is run.

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.

Staffing resources and the scheduling of care calls were still not managed safely and effectively in all parts of the service.

Further improvement was required to ensure people's medicines were managed safely.

Measures to prevent and control infection were not implemented consistently across the service.

Staff knew how to recognise and report any concerns to keep people safe from harm.

The provider assessed potential risks to people and staff and put preventive measures in place where these were required.

Staff recruitment was safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were provided with a range of briefings to help them remain up to date with relevant guidance and legislative requirements. But this was not reflected consistently in their practice.

People were not always supported to eat and drink at times of their choosing.

The provider provided staff with training and supervision appropriate to their needs.

Staff understood the principles of the Mental Capacity Act 2005 and reflected this in their practice.

Staff worked alongside local healthcare services when this was required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The provider was failing in its aspiration to deliver a consistently high quality, person-centred service which promoted people's well-being and comfort.

Individual members of the care staff team were kind and considerate in their approach.

Care staff encouraged people to have choice and control over their lives.

Care staff promoted people's dignity and privacy.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The provider's care planning system operated inconsistently.

The provider's response to people's concerns and complaints was not consistently effective.

Is the service well-led?

Inadequate

The service was not well-led.

Ongoing shortfalls in organisational governance meant people were still not receiving the safe, well-led service they were entitled to expect.

For the fourth inspection in succession, the provider was in breach of legal requirements in relation to the organisation of staffing resources.

Further work was required to establish a positive organisational culture and effective team working in all parts of the service.

Office staff did not communicate with people who used the service in a consistently responsive way.

The provider maintained a number of audits and surveys to monitor the quality of the service.

Homecare Helpline

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 announced. The provider was given notice of our inspection visit because the manager is sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that they would be available to contribute to the inspection.

The inspection team consisted of one inspector and three experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. Our inspector visited the administration office of the service on 20 March, 28 March and 11 April 2018. On 20 and 21 March 2018 our experts by experience telephoned people who used the service to seek their views about how well the service was meeting their needs.

Before the inspection we reviewed other information that we held about the service as notifications (events which happened in the service that the provider is required to tell us about) and information received from other agencies, including the local authority.

As part of our inspection we spoke with 36 people who used the service. Of these, 30 lived independently in their own homes in the community and six lived in extra care housing schemes supported by the service. We also spoke to four relatives of those people living independently, five members of the care staff team, the compliance officer, the manager and the managing director. We looked at a range of documents and written records including seven people's care files, staff recruitment files, medicine administration records and information relating to the auditing and monitoring of service quality.

Inadequate

Is the service safe?

Our findings

At our last inspection of the service in June 2017 we found the provider had not complied with a Warning Notice issued following our previous inspection and, for the third inspection in succession, was in breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had taken insufficient action to improve the organisation of staffing resources and the scheduling of people's care calls.

As part of our inspection of 20 March – 11 April 2018 we spoke to people who lived in the extra care housing schemes in which the provider maintained a 24-hour on site staffing presence ('the extra care service'). Everyone we spoke told us they were highly satisfied with the provider's staffing arrangements. For example, one person said, "I can't fault it. I've got regular carers. I have scheduled visits to assist with my medication … and a pull cord if I need [extra] help. It's great living here." Another person commented, "It all works like clockwork." Another person told us, "It all works very well. I have regular [staff] and we have a good chat." Talking about their experience of working in one of the extra care schemes, one member of staff said, "We've got a lovely little [staff] team here. We all work with [each] of the clients [and] get to know them. They like the consistency of seeing the same faces."

In marked contrast however, people we spoke with who lived independently in their own homes ('the community service') expressed their continuing dissatisfaction with the provider's approach to call scheduling, in particular the timeliness of their care calls. The majority (20 out of the 34 people and relatives we interviewed) told us of their concerns in this area and the negative impact it had on their lives. For example, one person said, "They give the [staff] too many [calls] and they are always running late. I just have to wait." Another person told us, "My morning time is 8.15am but they are coming after 9am which they did yesterday and do at weekends. This usually occurs when my regular one is off. Calls times are [also] duplicated between clients. How can they be in two places at once I ask?" Another person commented, "The evening call is getting earlier and earlier. One [staff member] came to put me to bed at 4.15pm."

A significant number of people (11 out of the 34 interviewed) also told us that staff were sometimes rushed and did not stay for the full length of their scheduled call. For example, one person said, "It is not the carers' fault [but] they have too many calls and some [scheduled] at the same times. Some … haven't got the time and rush off [without staying] the full time." Another person told us, "Sometimes they only stay 10 or 15 minutes. It's supposed to be a half hour meal call and 40 minutes in the morning, but you never get it. They are always in a rush. I try to make them slow down. I am not very happy." Another person said, "Some of them are in a right rush and don't always stay the full time."

We interviewed four staff who worked in the community service and all expressed concerns about the provider's approach to call scheduling and the impact this had on the timeliness of people's calls. For example, one staff member told us, "They don't give you enough travel time [between calls]. I don't think [the care coordinators who schedule the calls] realise how long it takes ... to get to villages and back." Another member of staff said, "[Sometimes] calls are back to back [with] no travel time. [It] has a knock on effect. Rushing [and] having to cut their times short." Another staff member told us, "At weekends it's

horrendous. [Our rotas] are absolutely rammed [full of calls]. We try our best [but] we've got to rush, rush, rush … to get onto the next call. It's awful."

In the light of the feedback we received from people and staff we reviewed the community service call schedules for 18 – 25 March 2018. Using data supplied by the provider, we looked at 895 calls scheduled on four of the eight days in this period. In confirmation of the feedback we had received, on 80% of the calls in this four day period, staff had stayed for less than the scheduled time. This included one 15 minute call where the staff member had stayed for one minute; two 30 minute calls where the staff member had stayed for 3 minutes and one 45 minute call where the staff member had stayed for four minutes.

Additionally, 168 of the calls in the four day period (18.7%) were late by 20 minutes or more. Worryingly, the percentage of calls that were late by 20 minutes or more had increased since our last inspection in June 2017 when the provider told us it was 10.1% in the month preceding that inspection. On 18 March 2018 alone, at least 23 calls (12%) were more than an hour late. It was particularly concerning to note that on 18 March 2018, of 14 calls which had been scheduled as 'time critical', 7 (50%) were late or early by 20 minutes or more, including two which were late or early by more than an hour. Time critical calls are those identified by the provider as being particularly important for staff to provide support at a specified time. For example to administer pain relieving medicine or to provide support to manage a long-term health condition. The provider's failure to ensure timely scheduling of some of these calls created a potential risk to people's health and well-being.

The majority of the people using the community service we spoke with (19 out of the 34 interviewed) also expressed concern about the lack of continuity in the staff providing their care and support. For example, one person said, "At weekends in particular I get different ones and never know who is coming or when. The same happens in the evening. Last week a new one just turned up. I didn't know her from Adam! I had to ask her name." Another person commented, "I never know who is coming or exactly when they will be here. New ones can just turn up." Describing the negative impact the lack of staffing continuity had on their well-being, another person told us, "There is not a lot of consistency. If they don't know you, they don't know if you are unwell or having a bad day. I prefer to have people who know me and know what needs to be done without me having to prompt them all the time."

Staff also shared their concerns about the lack of continuity in the provider's approach to call scheduling. For example, talking about one of their colleagues who had recently been recruited to the service, one staff member told us, "[Name] is doing 'double up' calls with me today [but] tonight [name] is doing singles on their own. All with people they have never met before [and who have never met [name]." Another member of staff said, "Clients are getting fed up [with the lack of continuity]." One person's relative told us, "[We] had [our] 87th carer come today. That can't be right. How are people supposed to get to know you and your needs?"

The manager told us that, since her appointment in November 2017, she had implemented a number of changes to improve staffing continuity and the timeliness of calls in the community service. These included enhanced call monitoring by the out-of-hours on-call team; utilising team leaders as a flexible resource to cover gaps in the staffing rotas; changing the role of the 'rapid response team' to focus on clients who were new to the service and the introduction of a regular report to monitor staffing continuity. However, when we asked people who used the community service if they had noticed any improvement in the scheduling of their calls, we received very mixed feedback. Seven of our 34 interviewees told us there had been some recent improvement. For example, one person said, "I made a complaint in December 2017 about missed and late calls. It has got better but times still vary." Another person said, "It used to be absolutely rubbish. Now it's just rubbish. There has been a small improvement over the last few weeks." A relative told us, "It is

improving slowly since [the manager] took over. I think she is trying desperately hard to sort it all out." Other people however told us they had detected no improvement. For example, one person said, "I think things have been worse lately." Another person commented, "I don't think much has changed since [the manager] started. I don't think they are well-coordinated. The rounds just don't appear sensible."

Taken together, the continuing concerns expressed by people using the community service about late and short care calls and the lack of staffing continuity and the very significant shortfalls identified in the analysis of call schedules in the period 18 – 25 March 2018, indicated the provider was still failing to organise staffing resources safely and effectively and schedule people's care calls to meet their needs and preferences. This meant, for the fourth inspection in succession, the provider was in breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection of the service in June 2017 we found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to the provider's continuing failure to ensure people received safe and consistent support with their medicines.

Following this inspection, the provider submitted an action plan outlining the actions that had been put in place to address this breach of regulations. These included medicines refresher training for all care staff and enhanced auditing procedures to ensure staff were maintaining an accurate record of any medicines support provided, an area where we had identified significant shortfalls at our June 17 inspection.

At our inspection of 20 March – 11 April 2018, we reviewed progress in implementing the action plan and found that the process of providing staff with refresher training had begun. 60% of staff had received their training and the manager told us that the remainder would be trained by June 2018. Describing changes she had made to the way the refresher training was delivered, the manager told us, "When I arrived … people were doing medication [and other refresher training] through [paper] questionnaires. I have abandoned paper based [refresher] training. When you sit and read a bit of paper, does it sink in? It is now done face to face [which] is much more productive. People will ask questions." In line with the action plan, the provider had also completed an audit of all medicine administration records (MARs) completed by staff in January and February 2018. Discussing her approach in this area, the manager said, "We have done all [the MARs] for January and February to give me an over-arching view of what's going on. [From March] we are moving to a (risk based) approach with some (MARs) audited monthly and others bi-monthly."

We looked at the February 2018 audit and saw that 30 people's MARs had been reviewed for that month . We selected the first 10 of these 30 records and saw that, without exception, the auditor had identified that staff had failed to complete the person's MAR charts correctly. In response, the manager had issued guidance to all staff reminding them of their responsibilities in this area. Although we were satisfied that the provider had taken sufficient action to address the breach of Regulation 12, the results of the February 2018 audit indicated that further improvement was required to ensure practice in this area was consistently safe.

The provider maintained a range of measures to help prevent the risk of infection. Care staff received food hygiene and hand-washing training as part of their annual refresher training and were provided with disposable aprons and gloves for use when providing personal care. However, one of the staff we spoke to during our inspection told us, "I wear gloves. I do have aprons but, I'm not going to lie, I don't wear them. I know I should. It's just a habit, not wearing one. I see other colleagues not [wearing aprons too]." This candid but alarming comment was confirmed by some of the people who used the service. For example, one person said, "They wear gloves but not aprons." Another person told us, "They always wear gloves but not so much the aprons." In the light of this feedback it was clear improvement was required to embed safe infection prevention practice consistently throughout the service.

We reviewed staff personnel files and saw that references had been obtained. Disclosure and Barring Service (DBS) checks had also been carried out to ensure that the provider had employed people who were suitable to work with the people who used the service.

Systems were in place to consider and assess potential risks to people's individual safety and wellbeing, for example risks relating to nutrition and skincare. People's individual care plans outlined the measures put in place to address any risks that had been identified. For example, staff had been provided with detailed guidance on how to support someone to use their shower safely. Senior staff reviewed and updated people's risk assessments on a regular basis.

Staff told they were aware of procedures designed to protect people from abuse. They said they understood how to report any concerns internally or to relevant external organisations such as the local authority safeguarding team and CQC.

The provider maintained an 'incident log' to record details of any significant incidents which had occurred in the service and the follow up action taken in response. Reflecting feedback from our inspector, the manager amended the incident form to make it clearer to identify when wider lessons had been learned and preventive measures implemented across the service as a whole.

Requires Improvement

Is the service effective?

Our findings

At our last inspection of the service in June 2017 we found the provider was in breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to the provider's continuing failure to ensure all staff had the training and supervision necessary to support people safely and effectively.

Following this inspection, the provider submitted an action plan outlining the actions that had been put in place to address this breach of regulations. These included the introduction of a 'supervision matrix' to monitor the provision of supervision in accordance with the provider's policy and enhancements to the training programme to provide staff with more opportunities to further their knowledge and skills.

At our inspection of 20 March – 11 April 2018, we reviewed progress in implementing the action plan and found staff were now provided with regular one-to-one and 'spot check' supervisions. Talking positively of a recent one-to-one office based supervision session, one member of staff said, "I had supervision the other day with [name]. We had a discussion about how I was getting on [and] any problems. They were happy with me and I was happy with them!" Describing a recent 'hands-on' spot check supervision, another staff member said, "I had [it] the other week. [Name] did it. [She said] I did well."

The provider also maintained a training matrix to ensure staff were receiving regular refresher training in areas including medicines, moving and handling and safeguarding. As described in the Safe section of this report, the manager had recently changed the delivery of this training from paper questionnaires to face-to-face. Talking positively about this new approach one member of staff said, "We are all in the process of doing refresher [training]. A catch up. It [has been] put in place since [the manager] arrived. Mine was supposed to be last week but the trainer was poorly. They are going to reorganise it. Some of my colleagues have done it and seemed happy." In addition to the changes to the provision of refresher training, the manager told us she had recently sourced some new distance learning courses in subjects including dementia, medication and care planning. Commenting on this initiative, one member of staff said, "I have been offered [the chance to study] one of the [new] short courses. [The manager] rang me up and offered it to me. I've not chosen which one I want to do [yet]."

The manager also told us she was supportive of staff who wanted to study for advanced qualifications including NVQs. Describing her commitment in this area she told us, "We have four staff doing NVQ2 at the moment. We will provide access to whatever they need [such as] policies and procedures. And give them time on the rota to meet with their assessor. I have [also] just sourced funding for NVQ3. I will mention this in the next newsletter."

New members of staff participated in an induction programme which included initial training and a period of shadowing an experienced member of staff before they started working on their own. Depending on their previous experience, new starters also completed the national Care Certificate which sets out common induction standards for social care staff. Commenting on their induction, one recently recruited member of staff told us, "I have NVQ3 so only needed to do a day and I didn't need to do the Care Certificate. We went

through medication charts, safeguarding, moving and handling. There were five of us. Three had been [on the induction course] for all three days [but two of us] joined for the day. It was fine."

At our last inspection in June 2017 some people expressed their concerns that some new staff lacked the skills and knowledge to care for them effectively. However, on this inspection almost everyone we spoke with told us that staff knew how to meet their personal care needs. For example, one person said, "They know how to use my hoist to move me from bed to chair and I feel quite safe with them knowing what they are doing." Another person told us, "They know about my stair lift and my swivel in the shower and how to move me about safely."

In the light of people's feedback and the improvements made to staff training and supervision since our last inspection, we found that the provider had taken sufficient action to address the breach of Regulation 18(2).

In addition to their training, staff were provided with a range of briefings to help them remain up to date with good practice guidance and legislative requirements. For example, in January 2018 staff had been issued with a fact sheet on norovirus. The provider was a member of the local care providers' association and the manager told us this was also a helpful source of information and advice. However, as described in the Safe section of this report, staff did not always wear protective aprons when providing people with personal care, increasing the risk of cross-contamination and infection. In the light of this worrying shortfall, improvement was clearly required to ensure staff worked consistently in line with good practice guidance and legislative requirements.

Most of the people we spoke with who required staff assistance with eating and drinking were satisfied with the support they received. For instance, one person told us, "They do me toast and a cup of tea for breakfast and for lunch, a cob to eat with a drink." Staff were aware of each person's particular likes or dislikes and the importance of offering people choice. Staff were also aware of the need to encourage people to keep well-hydrated. Confirming the approach of staff in this area one person told us, "They make sure I have enough water to hand as I cannot reach the taps. They always leave me with a full four pinter."

However, some people told us that the ongoing shortfalls in call-scheduling detailed in the Safe section of this report meant they were unable to enjoy their meals at times of their choosing. For example, talking to one of our experts by experience on the morning of the first day of our inspection, one person who was waiting for their breakfast call told us, "The [meal] times can be ridiculous and I get angry." Our expert by experience rang back later in the day and the person said they had received their breakfast at 11.15am and that their lunch call arrived at 3.00pm. Another person said, "They can be very late for lunch sometimes and then they are coming early for tea time. It's ridiculous as I am not hungry then." Further action was required to ensure the provider consistently met people's needs and preferences in this important area.

Staff were aware of the Mental Capacity Act 2005 (MCA). The 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. Describing the importance of reflecting the principles of the MCA in their work, one staff member told us, "Just because you need care and are old doesn't mean you can't make decisions about your care and lifestyle." Commenting positively on the approach of staff in this area, one person said, "They always ask what I would like to have done before commencing on anything." To reinforce knowledge of this issue, the manager had included an MCA quiz in the February edition of the staff newsletter with anyone answering all questions correctly having the opportunity to win a gift voucher. The manager had a clear understanding of formal best interest decision-making processes and told us she

would work closely with other agencies should these ever need to be considered for someone using the service.

Since her appointment, the manager had introduced a number of changes to improve team working and communication within the service. These included the launch of a new monthly newsletter; making more use of the internal messaging facility within the call monitoring system and the scheduling of more regular staff meetings. We noted that attendance at some of these meetings was very low with only five staff attending each of the community service meetings in March 2018. The manager told us she was disappointed with the poor turnout but that she would continue to schedule and promote the meetings as an opportunity for staff to get together to discuss issues and receive information collectively.

When necessary, staff also worked alongside a range of local health and social care services on behalf of the people who used the service, including district nurses and GPs. Commenting positively on the support they had received from staff in this area, one person told us, "They order my prescriptions for me and will make any appointments for me if I ask them to do so." Another person said, "I usually make my own appointments but they have, on one occasion, had to phone for me when I was unwell."

Requires Improvement

Is the service caring?

Our findings

In the 'Welcome to Homecare Helpline' information booklet which was given to people when they first started using the service, the provider had stated, "The Company is an enlightened … organisation that responds to, and is responsive of, the personal needs of individuals and families. Each service user we regard and treat as special. Homecare Helpline's philosophy is to provide its service users with a professional support and care service … with the principles of support, care, well-being and comfort being of prime importance."

However, for many people using the community service, the provider's chronic failure over a two-year period to organise staffing resources and schedule care calls effectively, meant that this commitment to supporting them in a caring, person-centred way was not being achieved. As detailed in the Safe section of this report, the majority of community service users we interviewed expressed their frustration and anger at the continuing prevalence of late and short calls and the lack of staffing continuity. In describing the negative impact this had on their well-being and happiness, people were very clear that their criticism was of the provider, not the individual members of the care staff team. For example, one person said, "It's not the carers' fault. The office needs sorting out. Call rotas and times." Another person said, "The office is poor. I would recommend the carers but the office does need to improve on things." Asked what one thing they would change in the service if they had a magic wand, one person told us, "I would like them to stay the full length of time." Another person said, "I would just like consistency of carers." Another person said, "I would like them to get here on time and stop swapping staff about." In the light of people's feedback it was clear that further action was required to make a reality of the provider's aspiration to deliver a high quality, person-centred service which promoted people's well-being and comfort.

As described above, almost everyone we spoke with in both the extra care and community components of the service told us that care staff were kind and caring in their approach. For example, one person said, "They are here to help and they do that well. They are very caring and I like having them come in. It's like having a friend care for you sometimes, as some of them know you so well." Another person told us, "They are all nice and caring and kind to me, whoever comes." People also told us that staff were thoughtful and attentive to their needs. For example, one person said, "The staff are helpful and look after me." Talking of one member of staff in particular, another person told us, "[Name] took my urine sample to the doctor for me to get it checked. She didn't have to do that but it helped me out."

Staff understood the importance of promoting choice and independence and people told us this was reflected this in their practice. For example, one person said, "I decide what needs doing and I tell them. They do what I ask of them." Another person told us, "I make my [own] choices about I what I want to have to eat and drink and when [to have] a shower." Describing their approach in this area, one member of staff said, "It's about getting to know people and how they like [things done]. Some like their tea very strong and others barely like the tea bag touching it. Some people don't like crusts on bread. It's all about their choices."

People also told us that staff were committed to supporting them in ways that maintained their privacy and

dignity. For example, one person said, "They are most respectful when showering me, making sure I get covered up when coming out." Another person said, " When taking me to my commode they leave me and come back a bit later if have called them. So my privacy and dignity is fine." The provider was aware of the need to protect the confidentiality of people's personal information. For example, care records were stored securely; computers were password protected and staff had been issued with guidance to ensure their use of social media was in line with data protection requirements.

The manager was aware of local lay advocacy services. She told us no one using the service currently had a lay advocate but that staff would not hesitate to help someone seek this kind of support, should it be necessary in the future. Lay advocacy services are independent of the service and the local authority and can support people to make and communicate their wishes.

Requires Improvement

Is the service responsive?

Our findings

The manager oversaw the handling of any new enquiries and referrals to the service. Describing how this process worked she said, "We get up to 10 [referrals] a week from [the local authority]. We look at how we can fit them into the existing rota. We take 99% of what comes through." The manager told us that almost all new referrals to the service were people who were being discharged back to their home from hospital and, for that reason, there was usually no opportunity to meet the person before they returned home and care calls commenced. The manager confirmed that she had no plans to amend the provider's referral process to enable staff to visit people in hospital to gain a fuller understanding of their needs and preferences in advance of the first care call.

The manager said that, within 48 hours of a person starting to receive care, the provider's compliance manager would book an appointment with them to discuss and agree their personal care plan and to identify and address any risks specific to the individual or their home environment. Pending the development of this document, the manager told us that staff would use the care plan supplied by the local authority at the time of the initial referral which set out the person's basic care requirements. However, two staff members told us that this system was not operating consistently in the community service. One member of staff said, "I went to a lady [recently]. It was her first call from the service. I didn't know she was new to the company until I got there. She [told me] this was her first call. There was no care plan, no folder in the home. [Luckily] it was an easy call, no medication. [And she was able] to tell [me] what she wanted." Another staff member said, "I [have] a new client. I think she started [yesterday]. [When I visited today] there was no care plan or anything in her house. Just some basics … [the staff member] who [did the first call yesterday] left in. A blank medication sheet and carer log. We carry [spares] of these [in case we run out]."

Additionally, the provider's compliance manager told us that she was in the process of updating people's care plans. However, as part of this exercise she had identified at least five community service users, some of whom were long-standing customers of the service, who had no personal care plan prepared by the provider, only the initial plan supplied by the local authority. Although, the compliance manager was in the process of making arrangements to visit these people to develop their individual plan, the shortfalls we identified in the provider's approach to care planning indicated action was required to ensure systems for assessing the individual needs and preferences of people who were new to the service operated consistently and effectively in the future.

More positively, the individual care plans which had been updated by the compliance manager were well-organised and set out clearly the detail of each person's care requirements for staff to follow. For example, one person's plan specified the assistance they needed to eat and drink. Staff told us that they found the re-designed care plans helpful when providing people with care and support. For example, one member of staff said, "The care plans are much better now." Another staff member told us, "I have seen some of the [updated] ones. They are helpful. They give a bit of extra information. A little bit of life history which can be a bit of a conversation starter. Some people have had really interesting lives." Commenting approvingly on their involvement in the recent review of their care plan, one person told us, "My care plan is being reviewed at the moment and I had full input into it. I am waiting its return." Another person said, "I have input [to my

care plan] and it was reviewed only last week."

The manager was aware of the new national Accessible Information Standard and told us she was in the process of incorporating this into the provider's approach for the future. In the meantime, care staff were aware of the importance of communicating with people in ways that responded to their individual needs and preferences. For example, talking of one person who had limited verbal communication, a staff member said, "I have my own little system with [name] as he has such limited vocabulary. I give him simple questions with yes/no answers [and] he shakes his head." Commenting positively on the approach of the care staff who supported them, one person said, "They … speak to me clearly. I like that." Another person told us, "Because of my condition they always talk me through what they are doing when hoisting me."

People who had expressed a preference for care staff of a particular gender told us the provider took care to respect their wishes. For example, one person said, "I have ladies. This is my choice, which they see to." Another person told us, "I only have ladies. I have told them that and they honour it." People also told us they felt that care staff treated them in a non-discriminatory way, whatever their background or current situation. For example, one person said, "[The care staff are] quite fair and [there are] certainly no discrimination issues, despite my condition."

At the time of our inspection, the provider was not providing support to anyone who required palliative, end-of-life care. The manager told us that people who needed this type of care would usually be admitted to hospital or referred to a homecare service which specialised in this area.

Details of how to raise a concern or complaint was included in the information booklet given to people when they first started using the service. The provider maintained a log of any formal complaints that had been received although the manager told us senior staff aimed to resolve any concerns as quickly as possible, to avoid the need for a formal complaint. However, despite this commitment to a proactive approach, people we spoke with had sharply differing views on the provider's response to any concerns or complaints they had raised. Commenting positively, one person told us, "I recently made a complaint and it was dealt with well." Another person said, "Since I complained [things] have improved. They used to call me once a week to see if things were okay after I complained. This has now dropped off to once a month but at least they are still doing it."

However, other people expressed their frustration at the provider's failure to resolve their concerns. For example, one person said, "When you call the office they always say they will sort it out but they don't. And they don't call back." Another person told us, "I have [raised concerns] about missed and lateness of calls. The response … is always, 'We will sort it out.' But they still haven't." Another person commented, "[I have raised concerns] about my call times which is ongoing and [has] not been resolved. They have not responded to me." In the light of this feedback, further action was required to ensure a consistently effective response to people's concerns and complaints.

Inadequate

Is the service well-led?

Our findings

People who used the extra care service told us they were highly satisfied with the management of the service. For example, one person said, "It's an absolute breath of fresh air. I can still get my independence but know support is there if I need it." Another person told us, "I would recommend it without hesitation." However, reflecting the ongoing concerns about call scheduling and communication with office-based staff described elsewhere in this report, the majority of the community service users we spoke with (19 out of the 34 interviewed) were critical of the way the service was run and felt unable to recommend it to others. For example, one person told us, "I wouldn't recommend the company. I don't believe it is very well-organised." Another person said, "I wouldn't recommend them. You can't trust them to be consistent. It needs more organisation."

At our first comprehensive inspection of the service in April 2016, we found the provider was failing to ensure the safe and effective organisation of staff resources in the community service. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In December 2016 we conducted a focused, follow up inspection to check the provider's progress in this area. We found the provider had failed to make any significant improvement and remained in breach of Regulation 18(1). We issued the provider with a Warning Notice requiring them to be compliant by 31 March 2017. We conducted a further full inspection of the service in June 2017 and found the provider had failed to comply with the requirements of our Warning Notice and was, for the third inspection in succession, in breach of Regulation 18(1). Reflecting this persistent failure to take action to meet legal requirements we found the provider to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and rated as Inadequate both the Well-Led section of our report and the service overall.

Following our June 2017 inspection, the managing director had written to the people who used the service apologising to those who had been affected by 'inconsistencies' in call times and advising them that 'staff across the company have been working very hard to …. deliver a more consistent service'. However, despite this commitment to improvement, as detailed in the Safe section of this report, at our inspection of 20 March to 11 April 2018, we found the provider was still failing to ensure the safe and effective organisation of staffing resources and scheduling of care calls in the community service and remained in breach of Regulation 18(1). Almost two years after we had first highlighted significant shortfalls in this area, it was extremely disappointing to hear of people's continuing concerns about late and short care calls and lack of staffing continuity and the negative impact this had on their lives.

The provider's chronic failure to take effective action to address the breach of Regulation 18(1) by organising staffing resources to meet people's needs and preferences indicated ongoing shortfalls in organisational governance which meant people were still not receiving the safe, well-led service they were entitled to expect. This was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As detailed elsewhere in this report, we were pleased to find that the provider had taken action to improve staff training and development and was no longer in breach of regulations in this area. The provider had

also taken action to improve the management of people's medicines and had addressed the breach of regulations in this area too, although further work was required to fully embed the changes to policy and procedures that had been introduced. However, in other respects the quality of service had not been sustained since our last inspection and, as detailed throughout this report, we identified the need for improvement in numerous areas including infection prevention and control; care planning; adherence to good practice and legislative guidance; complaints management and nutritional support.

There was no registered manager in post at the time of our inspection. However, the new manager appointed by the provider in November 2017 had submitted an application to become the registered manager and was waiting for this to be assessed by CQC. Describing her leadership style, the manager said, "I am very open and lead by example. I like to talk to staff to get an understanding [of their views]. I am very … approachable. Anyone can ring me up. Dom[icilliary] care is my forte. I have been a carer [myself] for many years [and have] an understanding of the pressures." The manager's accessible approach and extensive experience of domiciliary care was appreciated by staff we spoke with, most of whom felt she had begun to make a positive impact on the service in her first few months in post. For example, one member of staff said, "[The manager] knows where she wants to get. I have seen improvements." Another member of staff told us, "[The manager] makes you feel appreciated. Not just a number. It has got … better since she came on board." Another staff member commented, "I think things have got better since [the manager] arrived. She seems to really know her stuff."

As described in the Effective section of this report, the manager had introduced a number of initiatives to enhance communication within the staff team and boost morale. These included a monthly newsletter; sending staff cards on their birthday and new 'carer of the month' and '100% attendance' reward schemes. Describing the new carer of the month award, the manager told us, "[If someone] has received a compliment [from a user of the service] that month [their] name goes in the hat. [The winner] gets a £50 voucher [and] a certificate. It's just to let staff know they are appreciated. The only condition is they have to have their photograph in the newsletter." Some staff said they valued the manager's interest in their welfare and told us that this had had a positive impact on the atmosphere within the staff team. For example, one staff member who worked in the community service said, "I do think morale is better. I enjoy my work [and] would recommend it [to others]. [The manager] seems to have made it better. The certificates [make it] more rewarding." Another member of staff from the extra care service told us, "I definitely recommend it. We have a good team [here] and work well together." However, others were less complimentary, indicating further work was required to establish a positive culture and effective team working in all parts of the service. For example, one member of staff said, "I wouldn't recommend it. I've worked for so much better. I was in Tesco last week and a girl asked me who I worked for. I said 'Compleat Care' but advised her not to come over. It's not a team. If you are not in the clique, you don't stand a chance." Another staff member told us, "There is a lot of unhappy staff. Mostly complaining about the office staff." Another member of staff commented, "There is no team working here. No one helps each other out. I have been looking for other work to be honest."

As described elsewhere in this report, people were satisfied that front-line care staff communicated with them in a responsive, person-centred way. However, a significant number of the community service users we interviewed (13 out of 34) expressed concern about their experience of communicating with staff in the office. For example, one person told us, "The office staff just lie and waffle and are patronising. They make me feel victimised." Another person said, "[Communication] is poor from the office. For instance, I cancelled my [care plan] review last Wednesday as I had a hospital appointment. But [staff] still turned up and had not been told." Another person told us, "The office staff don't always listen when I ring them. Like last week [when] I was cross about the [call] times and knowing who was coming. They didn't even apologise and say they had things wrong." Another person commented, "They say they will call you back but never do." In

contrast, some people told us that they were happy with the response when they had contacted the office with any queries. For example, one person said, "I have the office number. The staff are very good and listen to what I need." Another person told us, "If I do ring the office about changing times or anything, it is sorted. No problem." However, the negative feedback we received from others indicated further work was required to ensure office staff communicated with people consistently and effectively.

As part of the process of monitoring service quality the provider continued to conduct an annual survey of people and their relatives. We reviewed the results of the 2018 survey and saw that these were broadly in line with the feedback from the people we interviewed as part of our inspection. For example, overall satisfaction was significantly higher amongst respondents who used the extra care service (94%) in comparison with the community service (77%). Additionally, community service respondents had given an overall rating of 92% to the question 'Care staff treat me with dignity and respect' but only 74% to the question '[Care staff] arrive in a timely manner' and 76% to the question 'I have regular care staff'. Some of the people we spoke with expressed dissatisfaction with the format of the survey tool. For example, one person's relative said, "The questionnaires don't really help you tell it as it is." Looking ahead, the manager told us the provider was trialling the use of a new quarterly survey tool based on the five questions of the CQC inspection process. The manager also said she had recently issued a new staff survey and was looking forward to reviewing the results.

In addition to customer surveys, the provider maintained a number of audits to monitor the quality of the service. These included regular medication, care plan and staff communication log reviews conducted by senior staff. The provider was aware of the need to notify CQC and other agencies of any untoward incidents or events within the service. Any incidents that had occurred had been reported and investigated correctly, in consultation with other agencies as necessary. The rating from our last inspection of the service was on display in the office and on the website, as required by the law.