Diamond Resourcing Plc

Better Healthcare Services (Norwich)

Inspection report

Wades Court
Bank Street
Norwich
Norfolk
NR2 4DT

Tel: 01603616999
Website: www.betterhealthcare.co.uk

Date of inspection visit:
17 February 2016

Date of publication:
27 April 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 17 February 2016 and we contacted the service before we visited to announce the inspection.

Better Healthcare Services (Norwich) provides domiciliary care to approximately 95 people living in their own homes, some of whom may be living with dementia or long term health conditions. The service procured a block contract from Norfolk County Council to deliver services to people in North Norfolk in November 2015. They are currently working in close partnership with Norfolk County Council to address issues highlighted in this report and to ensure service provision is maintained at an appropriate level.

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Although there were gaps in training, staff demonstrated the skills and knowledge to support people and meet their needs. However, their competency in their role had not been regularly assessed by the service. Staff had been safely employed following appropriate recruitment checks. Although regular supervisions had not taken place, staff felt supported by the registered manager and office staff. They demonstrated a commitment to the people they supported.

There were not enough staff to meet people's needs. The service had experienced a number of missed or late calls and this had had an impact on the service people received. A recruitment officer had been employed to assist the recruitment of staff and the service had a contingency plan in place. However, due to staff shortages and sickness the contingency plan had not been effective.

Staff demonstrated they understood the different types of abuse and knew how to report any concerns they may have. However, the service had not consistently reported safeguarding concerns to the local safeguarding team or the Care Quality Commission (CQC). The service had failed to consistently identify, assess and manage the risks associated with the people they supported and their staff.

Staff knew how to safely administer people's medicines. However, medicines were not safely managed because the associated records were inconsistent and did not always give a clear picture of what medicines had been administered and when. The service also did not consistently audit medicines administration in order to identify any issues and rectify concerns.

The service had been experiencing issues since the procurement of a contract in November 2015. As a result, the service had received a number of complaints. The service had not always addressed these promptly and some of the complainants were dissatisfied with how their complaints had been managed. The staff and people we spoke with who used the service had mixed feelings on how the service was addressing recent

concerns. Most staff had confidence in the service although not all people who used the service agreed.

The CQC is required to monitor the Mental Capacity Act (MCA) 2005 and report on what we find. Staff had variable knowledge of the MCA and some told us they had not received training in this. The service did not adhere to the principles of the MCA and people's human rights were compromised. However, staff did understand the importance of receiving someone's consent before assisting them.

Although people had initially been involved in their plan of care, regular reviews had not taken place. The care plans were generic and did not contain enough information to assist staff in meeting people's individual needs. People did not always feel their views were listened to.

People felt respected by the staff that supported them. They were treated with kindness and staff interacted with them in a courteous and warm manner. Their independence was encouraged by the staff that supported them although this was compromised at times when the service failed to meet calls.

People's healthcare needs were at risk of not always being met. Although the service had identified people's healthcare needs and medical conditions, staff had not been given enough information to effectively manage these needs.

There was a risk of the service not consistently meeting people's nutritional needs. This was due to staff having incomplete nutritional information for the people they were supporting to eat and drink.

People did not receive information on which staff member would be assisting them and when. This caused confusion and upset to the people who used the service, their relatives and staff. People felt unsettled by this and it impacted on their lives as they were unable to properly plan their days. People received support from a number of different staff, which did not aid continuity or consistency of care.

Proper processes for monitoring the quality of the service were not in place. Audits were few and sporadic. The registered manager did not demonstrate a full understanding of the service they were delivering. However, people had been asked for their feedback on the service and this had been fed into an action plan for improvement. This was ongoing at the time of inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The service failed to deploy enough staff to meet people's care and support needs.

The risks to people had not been effectively assessed, controlled or reviewed.

Medicines administration records were incomplete and did not indicate what medicines people had received and when.

People were not consistently protected against the risk of abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's human rights were compromised as the service failed to work within the Mental Capacity Act 2005.

People's nutritional and associated health needs were not consistently met.

People told us they were supported by staff who had the right skills and knowledge to meet their needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People felt frustrated as the service had not provided them with the information they required at a time they needed it.

People did not always feel listened to by the service.

The service involved people in their plans of care but did not consistently ensure their views were adhered to.

People benefited from polite staff who encouraged their independence and treated them with respect and dignity.

Is the service responsive?

Inadequate

The service was not responsive.

Although people were involved in planning their care, the service failed to supply staff with information to meet people's needs in an individualised way.

People did not receive continuity of care as they received support from a number of different staff, some of whom did not have knowledge of their needs.

The service did not fully investigate and respond to concerns in a timely manner.

Although staff were often late to arrive, people received care in an unhurried manner that allowed all their needs to be met.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The service had no effective system in place to monitor the quality of the service and drive improvement.

No system was in place to identify and manage the risks associated with the service. This put people at potential risk of harm.

People had confidence in the staff, registered manager and provider to address the issues the service was currently experiencing.

The service had gained feedback from the people who used the service and had used it to form actions for improvement.

Better Healthcare Services (Norwich)

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 took place on 17 February 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service. The management team sometimes spends time away from the office supporting staff and the people who use the service. Notice was given to ensure the management team was available to assist our inspection. The inspection was carried out by two inspectors. A third inspector spoke to people who used the service and their relatives.

Before the inspection we viewed all of the information we had about the service. This included statutory notifications that the provider had sent us in the last year. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law. We also contacted the local safeguarding team and the local quality assurance team for their views on the service.

During the inspection we visited the service's office, spoke with eight people who used the service and eight relatives. We also spoke with the registered manager, a care coordinator and seven care staff.

We looked at the care records for six people who used the service and medicines administration record (MAR) charts for three people. The MAR charts covered periods within the last six months. We also viewed records relating to the management of the service. These included complaints, four staff recruitment files, training records and quality assurance questionnaires.

Requires Improvement

Is the service safe?

Our findings

People who used the service did not consistently receive support as arranged with the service. One relative of a person who used the service told us, "They [the service] have a contract to provide care but they don't have enough people to cover. As soon as something happens or someone is sick or on annual leave, they're [the service] lost". Another relative of a person who required two staff members to support them said, "Sometimes one carer doesn't turn up. One time the carer waited 30 minutes and called the office to find out where the second carer was – they said they were trying to find someone – the carer themselves then rang a colleague to get them to come and help in between their other visits". This person also told us that they sometimes had to assist one carer as the second doesn't show up. They added, "All we want is a care company that can supply the care to my [relative], sufficient carers to cover calls and enough time for the staff to travel".

We looked at the records for missed and late calls. We saw that the service had 55 missed or late calls between 1 January and 16 February 2016. One relative of a person who used the service told us that their family member had failed to receive medication to manage their diabetes as a result of a recent missed call. We saw from the records we viewed that the service relied on family members to step in when visits were missed. For example, we saw that on one occasion a family member had to support their relative to wash and dress in order to attend a GP appointment when the service failed to supply a staff member.

We discussed the staffing levels with the registered manager. They told us they were currently eight full time care workers short of the required numbers. When we asked how this was being managed, the registered manager told us it was up to the office staff to cover shortfalls. The service had also recently employed an internal recruitment officer to assist with the recruitment of staff. In addition, the service had used an agency to provide care workers as well as introducing a financial incentive for office staff to be on standby to pick up missed calls. However, due to the consistent high number of missed and late calls we concluded that the actions taken by the service had failed to rectify the identified issues. The service had failed to deploy enough staff to meet people's care needs.

These concerns constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the service had identified the risks to the people they supported and their staff, these had not consistently been assessed or adequately managed. For example, we saw that one person who used the service lived with diabetes. Although the service had identified this, they had not assessed the risks to the person associated with their diabetes. We saw that staff assisted the person to manage their blood sugar levels. However, there was no risk assessment in place to direct staff to the potential risks to the person associated with high or low blood sugar levels. No information was available to staff to explain what actions they would need to take if the person became unwell in relation to their diabetes.

We also noted that the service had identified the same person as being at risk of infection. However, no risk assessment was in place to explain how to support the individual to remain well.

Staff had identified that another person who used the service experienced occasional falls. However, the service had not identified the level of risk nor documented any measures taken to minimise the risk of the person experiencing further falls. This risk had not been reviewed since November 2015.

Where the service had assessed risk, there was no clear system in place to demonstrate how the level of risk had been identified, controlled or reviewed. We concluded that the service did not consistently assess and manage risk in order to keep people free from the risk of harm.

These concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with who had assistance from staff to take their medicines had no concerns in how the staff completed this. When we spoke with staff about medicines administration, they demonstrated they understood how to safely administer and record people's medicines. They could tell us what they would do if they made a medicines administration error. The staff we spoke with told us they had received training in medicines administration.

We saw the medicines administration records (MAR) for three people who used the service. We saw that two of these three people had received their medicines as the prescriber had intended. We did note however that on one MAR there were four occasions of missing signatures in a month's period for one prescribed cream. There was no explanation given on the back of the MAR or in the associated daily notes. This meant we could not be sure that the cream had been administered as prescribed. We concluded that staff demonstrated the knowledge to safely administer medicines but medicines were not safely managed because records did not consistently give a clear indication of what medicines had been administered and when.

The staff we spoke with told us they had received training in how to prevent, protect and report the risk of abuse. Staff were able to tell us the different types of abuse and could give us examples of the changes in people that may indicate abuse was taking place. Staff knew how to report concerns both inside and outside of their organisation. We concluded that the service protected people from the risk of abuse.

We saw from the four staff personnel files we viewed that staff were employed following checks that ensured they were safe to work in health and social care. These checks included obtaining references from staff's previous employers and undertaking a criminal records check. We saw that health declarations and interview notes were on file although there were some gaps in these records. The staff we spoke with confirmed all checks had taken place prior to them starting in their role. We concluded that the service had employed staff following appropriate recruitment checks to ensure they were safe to work in care.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interest 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 interest and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

The staff we spoke with did not have a full understanding of the MCA and some told us they had not received training in this. Staff were unable to tell us who had capacity to make decisions for themselves. We saw from one care plan that the service had completed a blanket mental capacity assessment for one person they supported. The assessment was not time or decision specific as required by the MCA. It stated that the person lacked capacity as they could not communicate. A person's inability to communicate does not necessarily indicate a person lacks capacity. We noted that the service had agreed the person's care and support needs with their relative. However, the service had no evidence that the person's relative had legal authority to make decisions on behalf of that person. When we discussed this with a staff member, they were unclear as to the law in respect of the MCA and who could make decisions. They confirmed they would check whether the person's relative had legal authority to make decisions.

This constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with who had assistance from staff to prepare their food and drink told us they were offered choice and that their nutritional needs were met. However, people told us staff did not always arrive on time which resulted in them not receiving food and drink as arranged with the service or as required. For example, one relative of a person who used the service told us, "[Relative] likes to be as independent as possible so she needs to know who's coming at what time so she can cook for herself". When we looked at this person's care plan we saw that the service had recorded how important it was for this person to remain as independent as possible at all times. We looked at what times staff had arrived to assist this person over a two week period. We saw that arrival times differed on a regular basis and, on one occasion, by up to 105 minutes. This did not allow this person to adequately arrange their meal preparation.

Another person who used the service had assistance from staff with meal preparation. This person lived with diabetes and required a special diet to assist them to manage their condition. We looked at the care plan for this person. It stated staff assisted them with meal preparation but it did not give staff any information on what diet the person required in order to remain healthy. There was no further information available for staff within the care plan that told them how the person wished to manage their special diet. This potentially put the person at risk and did not assist them to maintain their day to day health needs.

All bar one of the people we spoke with who used the service told us they thought the staff that supported them had the right skills and knowledge to meet their needs. One person disagreed and said, "Some of the newer ones [staff] need more training". One relative we spoke with did express some concern about the induction received by staff. They told us their family member had been supported by a staff member who was unfamiliar with how to administer their pain patch medicine. All other relatives we spoke with were happy with the level of skills demonstrated by staff.

The staff we spoke with told us they had received training to fulfil their role. They told us this training was up to date and that it helped them to perform their role. We viewed the training records for the organisation. We saw that some staff had not received training in all aspects of their role such as health and safety, basic life support and safeguarding adults. When we spoke with the registered manager about this, they confirmed there were gaps in the training of staff but that a plan had been developed to address this.

Although staff told us they had not received regular supervisions, most felt supported by the registered manager and the office staff. One staff member we spoke with told us they found the office staff "understanding, empathetic and approachable". Another said, "The office staff are very supportive". A third staff member told us that although they had not had supervision recently, they felt confident that the service would arrange one if needed. Some staff told us they would like more staff meetings. One staff member said they felt staff meetings were even more important as the service had been going through some difficult times following the procurement of a new contract. When we discussed staff support with the registered manager they told us supervisions and spot checks on staff had not been maintained since taking over a new contract in November 2015. They explained that this was due to being short-staffed and having to assist other roles within the organisation.

Requires Improvement

Is the service caring?

Our findings

People told us they did not get the information they needed from the service at the time they wanted it. The people who used the service did not receive information on which staff member would be visiting them and at what time. People told us this upset them. One relative of a person who used the service told us, "Not having a rota is one of the biggest things". The staff we spoke with also said the people they supported had told them how unsettling this was. One staff member said, "People are getting really upset by it". Another told us how all the recent changes the service had gone through had affected the people they supported. They said, "People are unsettled – no rota, they don't know who's coming, different workers and different uniforms yet again".

We concluded that people did not consistently receive the information and explanations they needed at the time required.

People felt involved in their plan of care but told us their views were not always acted upon by the service. People who used the service told us the service had met with them to discuss what support they needed. However, some people told us their preferences were not consistently met. For example, one person told us, "I had to negotiate an earlier visit than ideal, but I'm ok with this as I can have a rest afterwards". One relative told us that their family member preferred a female staff member to assist them with their personal care. They said, "This isn't always possible at weekends so at times [relative] does not have a shower because of this". However, another person who used the service told us they had requested that a particular staff member did not support them and this had been adhered to by the service.

The people we spoke with who used the service spoke highly of the caring nature of the staff that delivered their care and support. One person said, "The carers are nice to me". Another person told us, "The carers themselves are excellent". One relative told us, "The staff that come are amazing; they're very good with my [relative]". Another relative of a person who used the service said, "These staff go out of their way to help. I wouldn't let anyone else do it. When the staff make my [relative] smile, it makes me so happy". A third relative we spoke with told us, "I trust the carers instinctively".

One person told us they received support from a number of different staff but that they all treated them with respect and dignity. They told us staff were polite towards them. They told us, "They [staff] sometimes come late but they always apologise". When we spoke with staff, they were able to demonstrate how they provided a compassionate service to the people they supported. One told us, "We [staff] don't want to let people down". Another staff member said, "I love my job and it's because of the people I support". Both the people who used the service and the staff members we spoke with told us that staff members often made arrangements amongst themselves to make sure people received a visit. People told us this was because the office were not always organised and, as a result, visits were missed off the staff member's rota. The staff we spoke with were able to give us examples of how they promoted people's privacy, choice and dignity.

Staff promoted and encouraged the people they supported to be as independent as possible. One person who used the service said, "They [staff] encourage you to do as much as you can for yourself".

Inadequate

Is the service responsive?

Our findings

People told us they weren't always informed when a staff member was running late. One person told us, "Sometimes they don't ring up when a carer has rung the office to ask them to let me know they're running late and to tell me why". This person went on to explain that not knowing what time a staff member would be arriving didn't help them to be independent as they couldn't prepare their day. Another person said, "They used to give you a rota but now I don't know who's coming from day to day". A relative of a person who used the service told us, "[Relative] is 90 and they could have an extra hour in bed. We get up at 6.30am every morning". They explained this was because they did not know what time a staff member would arrive. The relative went on to say, "The carers need to be on time because [relative] goes out twice a week and needs time after showering to recharge otherwise [relative] gets flustered".

Another relative told us the service "occasionally" called their relative to say they can't make the visit but at other times had not turned up without any explanation. The relative gave an example of where it was important a staff member supported their family member on an early morning visit as they had an appointment. The relative told us they had called the service the day before the appointment to ensure a staff member would be attending their family member. On the day of the appointment, no staff member turned up and the office did not call to provide an explanation till after the appointment time. The relative told us they were finally given two different explanations to why a staff member failed to visit their family member as arranged with the service. The relative told us, "The organisation of the carers is awful to the point of being dangerous. If [relative] tried to bath themselves or take something out of the oven…"When we discussed people's needs with staff members one told us, "It's exhausting for people having to explain what they need to different staff members". Those staff that had recently taken on new clients told us they didn't have enough information on the person prior to their first visit. One said they were given "basic information". A second staff member told us they had to rely on themselves to ensure they had enough information as the office didn't give them the information they needed. Another staff member said they "never" received information on people prior to visiting them for the first time.

The service had met with the people who used the service to assess and plan their care. However, they had failed to produce and review plans of care that supported people to have their needs met in a person-centred way. The people we spoke with told us these needs were not always met.
The six care plans we viewed lacked information to ensure people received care and support from staff in a way that met their needs. All six care plans we viewed contained generic care plans and risk assessments that did not take into account people's individual needs. For example, one person lived with diabetes but did not have a care plan in place to assist staff to support them with this. A second care plan we viewed did not give staff information on how to support a person living with dementia. Although the care plan gave an outcome to be achieved for this person, it did not give any information on how this was to be achieved and it did not relate to the identified need. A third care plan identified that a person had physical restrictions as a result of an injury but there was no guidance on the person's needs as a result of this or what assistance was required. One person who used the service told us staff failed to consistently visit at a time which ensured they could attend their local church for worship.

When we discussed this with staff, they gave us mixed opinions on the information the care plans contained to assist them to support people. Three of the staff we spoke with felt the care plans gave them enough information. One staff member said, "The care plans are not very clear at all. I go in blind sometimes and have to rely on the care notes rather than the care plans". A second staff member said, "Care plans are good but they're not always updated when changes occur". A third staff member told us the care plans weren't being updated or written in on a regular basis.

We concluded that the service did not give staff enough information to support people to have their individual needs met in a person-centred way. The service had also failed to review people's needs on a regular basis.

These concerns constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we discussed continuity of care with people who used the service they told us they were happy with the regular staff that supported them and that they knew their needs. However, a number of people reported that they received visits from a wide variety of staff that did not know them well. One person said, "Different people come every day". Another person said, "This morning's carer was very late as she didn't know the area at all and hadn't been told about how to get in my house". This person reported that they had had lots of new staff members and told us, "If I could only have the same kind of people as before instead of all the odds and ends".

When we discussed this with the registered manager they told us that the service aimed for no more than three or four care workers to assist one client. However, due to staff shortages, this was not currently happening.

The people we spoke with who used the service and staff told us they had enough time to meet people's needs. People told us staff stayed for the allocated amount of time and completed all the care and support required. However, people and staff told us staff did not get enough time in between visits which sometimes had an impact on the service delivered. For example, one relative told us their family member's regular care worker was only allocated five minutes for a journey that took 13. They told us this meant that care workers were often late or didn't arrive at all which meant the relative had to step in to support their family member. One staff member said the organisation of routes for the staff was "off the scale". They explained that they had been allocated five minutes for a journey that regularly took forty minutes due to traffic.

The people we spoke with who had made a complaint regarding the service they had received from Better Healthcare Services (Norwich) were not happy with how the provider had managed their complaint. One relative told us that the registered manager had met with them to discuss concerns they had about the service their family member was receiving. They told us the registered manager spent a great deal of time listening to their concerns but that they had not had any contact from them since and that, "Nothing has been done to address the concerns raised". Another relative told us they had made a complaint but did not have any contact from the service until a number of weeks later. The relative explained that, at the time of the incident that resulted in the complaint, Better Healthcare Services (Norwich) on call service had shown little concern for their complaint and had given them advice that showed a lack of care. The relative told us the registered manager had called them some time after the incident to apologise.

When we discussed the complaints procedure with the registered manager they could not give us a clear overview of the current status of complaints. They did not know which complaints had been escalated to their line manager or at what stage they were at. When we looked at the complaints records we saw that a

complaint that had been made in December 2015 had yet to be investigated. Another complaint showed that the concerns had been escalated to the Operations Director as the complainant had been dissatisfied with the outcome of the investigation. Records showed this happened on 14 January 2015 however there was no evidence that further action had been taken. When we asked the registered manager about this they could not tell us the status of the complaint. An additional complaint showed that the complainant was not satisfied with the outcome of the investigation and that the complaint was ongoing. We concluded that the service failed to fully investigate complaints in a timely manner. They had not used the concerns raised to improve the care, treatment and support that people received.

These concerns constituted a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

The service did not have any structured quality monitoring auditing systems in place and therefore lacked effective drive for improvement. When we discussed this with the registered manager they told us the service did not collect information on the quality of the service. They told us that there was no plan in place to support improvement. When we asked the registered manager what they thought the quality of the service was, they told us they thought the service was disorganised and, in that respect, the service was "poor". They told us, however, that they thought the service was "good" at the point of delivery.

When we asked to see the quality audits for the service the registered manager could not produce these. We saw some audits had been completed on daily records but these were sporadic and ineffective. For example, we saw that one audit had picked up on an issue with the medicines procedure. The record did not show that the concern had been passed on to the registered manager as required. When we discussed this with the registered manager they told us they were aware of the incident. When we asked what the procedure was for any concerns raised from audits, they told us concerns were inputted onto a system which recorded the actions taken. We asked to see these records but the registered manager could not locate this incident on the system. We therefore concluded that the service did not have effective quality monitoring systems in place that sought to drive improvement and development.

The service had failed to have systems in place to identify, assess and monitor the risks to the health and safety of those who used the service and others such as staff and visitors to the office. For example, we saw that the service had identified that a person using the service had a pet dog. However, although the service had completed a safety in the home risk assessment, it had failed to identify this as a potential risk to staff.

When we asked the registered manager how they managed the risks to their staff associated with lone working in the community, they could not tell us how they achieved this. When we asked to see the associated risk assessments, the registered manager told us these had not been completed. We saw from the organisation's Lone Working Policy that the organisation had a duty to its employees to assess any risks to lone workers and take steps to avoid or control those risks where necessary. We concluded that the service had failed to do this. The service had failed to have systems in place to protect people from the risk of harm.

These concerns constituted breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the procurement of a new contract in November 2015, the service had experienced a number of issues that had impacted on the service people received. When we discussed this with the registered manager they told us they had not been fully prepared and information was lacking prior to the commencement of the contract. The registered manager was open and honest in his approach. However, although the service had implemented an action plan and identified some of the issues highlighted in this report, concerns were still being raised.

When we discussed these issues with the people who used the service, their relatives and staff, they had mixed views on the current status of the service. One relative told us they were thinking of using another service following an increase in their family member's needs. They told us they were reluctant to do this but they did not believe Better Healthcare Services (Norwich) could deliver the service required due to lack of communication and organisation. Two other relatives of people who used the service felt the provider did not value their staff. One said, "If they don't show that they value their carers they will lose more". However, one person who used the service told us, "[Registered manager], who is in charge now, seems like a nice person and I'm sure they are doing their best".

Most of the staff we spoke with had confidence in the registered manager and provider. One told us, "They're trying their best to put things right but are not on top of things". Another staff member said, "To their credit, they've [the service] made amends to put things right". A further staff member said, "They've [the service] always done everything they've said they will".

The staff we spoke with felt they worked well as a team and felt let down by staff that had recently left following issues within the service. One staff member said, "We're trying our best to help the office. We're really dedicated and we are not going to let the clients down". Another staff member told us, "The staff work incredibly hard. I've never seen anything like it". Staff consistently told us that they often organised their work amongst themselves and covered each other as required. It was clear they were dedicated to the people they supported and the service.

Staff told us they would like more meetings especially as the service was experiencing issues. They told us they mostly felt listened to by the service but that they would like more opportunities to express their views. One staff member said, "They [the service] try to listen to us but they need to take more notice of the carers". This staff member went on to explain their frustration in the service continuing to be disorganised. They said, "There just needs to be better planning". Another staff member, who told us the service had run smoothly prior to November 2015, said, "There's such poor management of rotas and routes". Although they stated this was slowly improving.

The service had recently sent questionnaires to people who used the service to gain their feedback. These had been collated and we could see from the action plan the service had implemented that people's views had been included in this. For example, the action plan had identified that people said they wanted a roster so they knew what staff member would be assisting them and when. This was included on the action plan and showed the action was ongoing.

We know from the information we hold about this service that they have not reported all events via statutory notifications as required by law to the CQC. However, the registered manager has had an open and transparent approach when discussing the current status of the service and the problems this report has highlighted. The service is currently working in close partnership with other agencies to support the care provision and service development.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The service had failed to provide staff with information that ensured people's needs were met in an individual way. Regulation 9(1) (2) and 3(a)(b)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service had failed to work in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. Regulation 11(1)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Although the service had identified the risks to people, these had not been consistently acted upon in order to keep people safe. Regulation 12(1) and (2)(a)(b)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Effective systems were not in place to ensure

complaints were investigated without delay.

Regulation 16(2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not have effective systems in place to assess and monitor the quality of the service. Regulation 17(1) and (2)(a)(b)(c)(f)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service had failed to deploy sufficient numbers of staff to meet people's care and support needs. Regulation 18(1)