Axe Valley Home Care Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was announced and took place on 27, 28 April and 3 May 2016.

Axe Valley Homecare Ltd Dorchester Office is registered to provide personal care to people living in their own homes. At the time of our inspection, the service was providing support to 50 people. The service was run out of a central office outside Dorchester.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Risks to individuals were not safely managed by the service. The risk assessments and moving and handling assessments were not individual and did not provide information about how to manage people's risks.

The provider's system for highlighting people who required time critical visits was not safe. The registered manager provided us with a copy of the people who were scheduled to receive time critical visits in the week prior to the inspection. One person with diabetes was not included on this schedule and their visits varied by two and a half hours over the week.

Medicines were not recorded correctly on Medicine Administration Records (MAR). There were gaps in the recording for all of the MAR. Staff had recorded that medicines had been administered in people's daily records. People told us that they received their medicines appropriately.

We saw that some people received their medicines from a pre-packed system which was dispensed by the pharmacy to people's homes. These people had a MAR which recorded that the medicines in the system had been taken but did not include details of what medicines were included in this system, any prescription directions or the dosage. This did not follow current guidance for safe administration of medicines..

Most people and relatives told us that they felt safe with the support from the service and that they received visits when they should. People told us that they knew the staff who visited them and generally had the same staff.

Staff received training as part of their induction and received refresher training in certain areas annually. Staff had undertaken training in four main areas, safeguarding, mental capacity, manual handling and medication administration. Some staff felt that they had the right training to support them, but others felt they required other training opportunities. Most people, relatives and health professionals told us that they did not think staff had the right training to support people's needs.

People and relatives all told us that communication was difficult with some members of staff. Healthcare professionals commented that communication was an issue. A district nurse had observed that a carer did not seem to interact on a visit and a relative explained that the limited English of some staff was a problem for their relative.

The registered manager told us that no-one at the service had a capacity assessment in place but that people completed consent forms for staff to administer medication and the service was currently reviewing its MCA paperwork. Staff were able to tell us how they sought peoples consent.

People and relatives told us that staff were kind. Staff knew peoples preferences and how to support them. Two members of staff told us about people that they supported and their personal preferences. For example one person had a very detailed routine and the staff member was aware and able to explain this.

The service did not always listen to peoples choices and preferences. One person said that the biggest improvement the service could make would be "to listen to what we want".

People and relatives received a weekly rota telling them who would be visiting and when. People told us they were not consistently informed about changes to their visits.

People and relatives told us that they were involved in reviews of their support. One person told us that they were involved in the planning of their care and that this was thorough. ". The registered manager did not have details of what had been discussed or updated at reviews or oversight of any themes or trends from peoples reviews.

Staff knew peoples preferences and how they liked to receive support. We observed relaxed and easy going support form carers who knew the people they were supporting, however staff told us that they did not always have sufficient information about how to support new people.

Quality Assurance systems at the service were not robust. Medication audits were not robust or collated which meant that the registered manager was not aware of themes in medication administration errors. There was no consistent process for frequency of staff reviews and peoples care reviews were not audited. We saw that reviews were not comprehensive and the registered manager was not able to see what areas had been discussed at review. The registered manager completed spot checks, had an overview of when reviews were due and showed us evidence of this.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to safe care and treatment of people(Regulation 12) and good governance of the service(Regulation 17). You can see what action we told the provider to take at the back of the full version of the report.

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

Risks to individuals were not managed safely by the service.

People knew the staff supporting them and visits were generally at the scheduled time.

Medicines were not recorded correctly on Medicine Administration Records (MAR).

Sufficient recruitment checks were completed for new staff.

Is the service effective?

Requires Improvement

People, relatives and staff reported that communication with some carers was an issue.

Staff were able to tell us how they sought consent from people and offered choice.

People, relatives and staff had mixed views about whether staff had sufficient training to support peoples needs.

People were supported to access healthcare services promptly.

Is the service caring?

Good

People and relatives told us that staff were kind in their approach.

The service did not always listen to peoples choices and preferences.

Staff treated people with dignity and respect when they supported them.

Is the service responsive?

Good

People were not always told about changes to their visits.

People and relatives were involved in reviews about their support.

Staff knew the preferences and how people liked to be supported.

Feedback was gathered from people, collated and discussed by management.

Is the service well-led?

Requires Improvement

Quality assurance audits were not comprehensive and did not provide an overview of themes or trends at the service.

People and relatives told us that they were able to speak to someone in the office easily when they needed to.

Feedback and issues relating to communication between staff and people who received a service had not been effectively managed.

Communication between staff and management was not always good and practice updates were not regular.

Axe Valley Home Care Ltd

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 and took place on 27, 28 April and 3 May 2016. Further phone calls were completed on 29 April and 4 May. The provider was given 48 hours' notice because the location provides a domiciliary care service to people in their own homes and we needed to be sure that someone would be at the office and able to assist us to arrange home visits.

The inspection was carried out by one inspector and an expert 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.

Before the inspection we reviewed information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including injuries to people receiving care and safeguarding concerns. We reviewed the notifications that the service had sent to us and contacted the local quality assurance teams to obtain their views about the service.

The provider had not completed a Provider Information Return(PIR) because we had not requested that they do so. A PIR is a form that asks the provider to give some key information about the service, what the provider does well and what improvements they plan to make. We gathered this information during the inspection.

We spoke with five people in their homes and six relatives. We also telephoned 12 people to obtain their views about the service. We also spoke with five members of staff and two health professionals. We spoke with the registered manager and two directors.

We looked at a range of records during the inspection. These included seven care records and three staff files. We also looked at information relating to the management of the service including quality assurance audits, policies, risk assessments and staff training.

Requires Improvement

Is the service safe?

Our findings

Risks to individuals were not safely managed by the service. Staff completed an initial assessment with people when they first started receiving support from the service. This assessment included completing a generic risk assessment document which covered areas including whether the person used anything to assist them to walk and any trip hazards or risks at the property. People had moving and handling assessments which identified whether they were a low, medium of high falls risk based on a traffic light system.

The risk assessments and moving and handling assessments were not individual and did not provide information about how to manage people's risks. For example, one person's assessment placed them at a "yellow" or medium risk of falls. There was no information for staff about how to manage this risk or what the "yellow" risk categorisation was used for. A risk assessment stated that the environment was cluttered and there was a confined space. Again this placed them at a "yellow" or medium risk but there were no further details about how these identified risks were to be managed. Another person used equipment to support them to move safely, including a hoist, slide sheets and a profiling bed. Their care record included information provided by an Occupational Therapist(OT) about correct use of a sling, however there were no details about how to use the other equipment with this person. The registered manager told us that a supervisor had met with the OT and cascaded information to other staff. and We spoke with two members of staff about this and one was aware of what sling loops to use, however confirmed that this was not documented. The other member of staff was not aware of this and was not able to find this information in the person's records.

People did not have individual risk assessments which were specific to their needs.. For example, one care record we looked at highlighted that a person had a catheter. There was no risk assessment or detail in the file to identify the risks associated with the catheter or instruction about how to manage this. The record did detail that the district nurse team managed the catheter for the person. However the care record did not provide staff with guidance about the risks, what to check or what to do if there were any issues.

One person was diabetic and that district nurses visited to manage this. There were no details in their care record about what diet choices would be appropriate or signs and symptoms to be aware of with regard to the diabetes. A district nurse told us that they would expect staff to have an understanding about diabetes and to encourage the person to eat the correct foods and for this information to be in the care records for the person. The person told us that they did not feel that staff had a good understanding about diabetes. The registered manager told us that the care record advised that the person had diabetes and that staff covered diabetes in their induction training. They felt that this managed the risk and said "I would be shocked if they don't know that as that is what they are trained for". We spoke with two members of staff who said that they had not received any training in diabetes. Training records showed that diabetes training was covered as part of induction for new staff.

The provider's system for highlighting people who required time critical visits was not safe. One member of advised us that if someone had diabetes their visits would be recorded as time critical on the system. This

would mean that the office and staff would be aware that visits needed to be at a set time for a particular reason. The registered manager provided us with a copy of the people who were scheduled to receive time critical visits in the week prior to the inspection. One person with diabetes was included on this list, another person was not included. We saw the persons rosta and saw that morning calls for the week prior to the inspection varied in times by 3 hours From 07:55 to 10:28. The relative explained that lots of different times affected their relative's insulin and sugar levels and they had fed this back to the service over a month ago.

This was a breach of regulation 12 (1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not recorded correctly on Medicine Administration Records (MAR). There were gaps in the recording for all of the MAR. Staff had recorded that medicines had been administered in people's daily records. People told us that they received their medicines appropriately. One person said, "Carers always help me with the tablets" and another said, "They help me with my medicines every day". Staff were able to tell us what medicines people took and how to record these. One told us they initial the MAR and record "if already taken, if refused then we are supposed to call the office and dispose of the medicine". Another told us "I read in the care plan what I need to do, give them their medicines with water and record this. If refused I ring the office".

MAR records showed significant gaps in some cases. For one person, they received a medicine twice daily. This was noted in their care plan, but the MAR did not give details of dose or frequency of this medicine. For the month of March the MAR indicated that the medicine was given on 19 mornings and five evenings. In February no evening administration was recorded and eight morning doses were signed for. One of the directors commented that "there are a lot of gaps" when shown the MAR chart for this person. We spoke with a member of staff who was aware of the dosage and frequency of the medicine and a district nurse confirmed that the medicine was prescribed to be taken twice daily. From the MAR record it was not evident that the person had received their medicine safely.

We saw that some people received their medicines from a pre-packed system which was dispensed by the pharmacy to people's homes. These people had a MAR which recorded that the medicines in the system had been taken but did not include details of what medicines were included in this system, any prescription directions or the dosage. This did not follow current guidance for safe administration of medicines.. We looked at the records for five people using this system and found that none of the MAR included details of what medicines were included in the system. This meant that administration was not recorded accurately and it was not possible to determine what medicines someone was taking from their MAR.

For each of the five MAR where a dispensing system was used, all had gaps in the MAR . For example, one person had medicines administered from a system at lunchtime. In February the MAR showed gaps on four dates at the lunch call and in March the MAR showed gaps on three dates. For another person, the March MAR showed gaps on three occasions at lunchtime and on one morning.

This was a breach of regulation 12 (1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people and relatives told us that they felt safe with the support from the service. One person told us "yes, I feel safe, their main job is my care and they make sure I am up and about and that's safe in itself". One relative told us that once they got to know the staff, they felt their relative was safe with them. Another relative said that their relative had not had any accidents so they felt that they were safe. Another told us that their relative felt safe in the company of staff, however another relative told us that experienced staff

leaving recently had made them feel less safe.

Most people told us that they received visits when they should. Two people told us that there had been an occasional call missed due to staff sickness or other issues but that this had not caused any issues for them. Other people told us that staff always arrived and calls were never missed. People also told us that staff stayed for the allocated time for each visit. One said staff "stay for the full time. They sometimes stay over the time if there is anything extra I need". Another said "they are usually on time and stay what they are supposed to".

People told us that they knew the staff who visited them and generally had the same staff. One person told us that staff were "generally consistent" and another said that they had the same number of carers who supported them each week. Another told us " I have a rota of four carers and all are familiar to me" and another said "I know my carers as they are the same ones I get". One relative told us that they knew the carers who were visiting, but had had several new carers the week we spoke with them. Another told us that they "tend to keep the same carers on the same rounds".

Staff understood about the possible signs of abuse and how to report any concerns. One person told us that they would "gather the information and pass it to the registered manager". Another said that they would discuss the concerns with their supervisor and another was able to give us an example of a possible disclosure of abuse and how they would manage this. Staff received safeguarding training and that this was updated annually. Staff safeguarding training was up to date.

Not all staff were aware of how to whistle-blow. We spoke with two members of staff who were not able to explain what whistleblowing was and had not heard of the policy. A different member of staff said that they "would be confident to whistle-blow, my clients come first". The registered manager told us that the Whistleblowing policy was included in the employee handbook which was given to all staff. We were given a copy of the handbook dated April 2016 but the policy was not contained in it. The registered manager subsequently showed us a copy of the policy. They advised us that the document was in the process of being updated and we saw that it included details of what whistleblowing meant and how to raise concerns.

Staff told us that they generally had sufficient travel time between visits and that there were enough staff to support people. One member of staff said that travel time between some people was not long enough, but for others it was sufficient. Another member of staff explained that travel time was calculated on the system and that visits were booked in patch areas where possible to reduce travel times. Two other staff members told us that travel time was enough.

The registered manager told us that recruitment was extremely difficult. They explained that they had tried various methods of recruiting staff but that there were ongoing issues with this. The service recruited some of its staff from outside the UK and used recruitment agencies to support them to carry out the necessary pre-employment checks. We looked at the records for three members of staff and saw that appropriate identity and Disclosure and Barring Service (DBS) checks had been completed. For staff recruited from outside the UK, we saw evidence that criminal record checks had been completed in the persons own country and these were on file. However, one member of staff was working in the community without the full DBS check having been received. The director told us that they had been shadowing and that the service was completing "active monitoring" with this member of staff. They showed us the checks that they had made with people to monitor this member of staff and saw that they had monitored seven times in a two week period.

The registered manager told us that they used the local authority plans for winter planning at the service. This focussed on how the service would support people in an emergency, for example severe winter weather or a heat wave. The service did not have a list of which people would be a priority to support in an emergency situation. The registered manager told us that "we know our clients and what their needs are". They advised that "we don't need a separate emergency plan as we all know them and can look them up individually" to establish who would be a priority need to visit. This meant that in an emergency, there would be no immediate method of clearly establishing who would be at greatest risk and a priority to support. People had also not been consulted or advised about what would happen in an emergency situation, for example, if they may be considered a low priority and therefore not receive a visit.

Requires Improvement

Is the service effective?

Our findings

Staff received training as part of their induction and received refresher training in certain areas annually. Staff had undertaken training in four main areas, safeguarding, mental capacity, manual handling and medication administration. Some staff felt that they had the right training to support them, but others felt they required other training opportunities. One member of staff told us that the training they had received was sufficient. Another told us that they did not feel the manual handling training was good and that they needed more practical sessions. They also felt that practical training in areas such as catheter care and diabetes was required. Two staff did not think that they had received training in mental capacity.

Most people , relatives and health professionals told us that they did not think staff had the right training to support people's needs. One person said that staff "do not know what they are doing, they ask me". Another told us that they didn't feel that staff knew much about their health condition. Two relatives told us that they did not feel that staff had a good understanding about dementia. One relative told us that staff "are observant, they have shadowing and learn from people who already know them". Another relative told us that a new member of staff had been shadowing someone to learn how to support them. A district nurse explained that they had observed staff at a visit and felt that the "manual handling was not being done as well as it should have been". The registered manager told us that staff received training in other areas either when it was "asked for by a carer, or when they are observed by a supervisor as not competent". They told us that training was provided by an internal trainer who came to the office to deliver training.

Staff completed refresher training and that this covered the four main areas and in some cases, additional areas. For example three people had received training in care records in addition to the four main topics. Another member of staff was booked to attend catheter care awareness training .

Two members of staff told us about the training they received as part of their induction. Both had also completed shadowing visits before lone working in the community. We saw training records which showed that topics covered during induction included person centred support, dementia, safeguarding and how to communicate effectively.

People and relatives all told us that communication was difficult with some members of staff. One member of staff told us that clients they had visited had told them they were not happy with the language barrier between themselves and staff and that one person told them that a member of staff had called them a baby. One person told us that a member of staff had said "I no understand you" when trying to discuss what support they needed. Another person said "they don't understand English very well, some are ok". Another commented that "often they can't understand me and I can't understand them, might as well just give up". Another told us that "some are better than others, some of their English is very, very bad". Another person told us "I find it difficult as most of them can't speak English. They have a heavy accent and I can't understand them. I get frustrated".

Healthcare professionals commented that communication was an issue. A district nurse had observed that a carer did not seem to interact on a visit and a relative explained that the limited English of some staff was

a problem for their relative. Another relative told us that some more recent staff "don't seem to have a good grasp of the English language". Another relative told us that "it can affect my relative when their English is poor". Another district nurse told us that they had been concerned about the manner of one member of staff when speaking with a person and felt that "there was an element that English was not their first language".

We spoke with people and saw records that people had rung raising issues with communication with staff. One person told us "I have complained about the carers lateness and their language and I can't understand them. The office don't seem to be doing anything about it". One member of staff told us that there were "language barriers at times and clients tell me this regularly".

The director advised that staff received supervision twice a year, with one of these also being used for their annual appraisal. They advised that they were reviewing the appraisal documents and had boosted their supervision team to increase the number of supervisors at the service. In addition to supervision, staff also received observational supervisions. We saw that the observations covered several areas of practice including recording, communication and appearance. When issues or improvements were recorded, these were feedback to staff via email and actions planned including follow up observations and additional training. The director advised that there was no consistent criteria to inform how often observations were to be completed or what follow up actions would be taken. Staff told us that they received supervisions and that their practice was observed. One said they "discussed any struggles and issues and what we can do to improve". Another told us that they had been "observed step by step on what I did".

The registered manager told us how they developed best practice. They advised that they linked with the local councils and health professionals and attended a monthly management meeting. They also told us that they used Skills for care for guidance in best practice.

The Mental Capacity Act 2005(MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The registered manager told us that no-one at the service had a capacity assessment in place but that people completed consent forms for staff to administer medication and the service was currently reviewing its MCA paperwork. One of the directors showed us the proposed paperwork which they advised had been copied from another source. We advised them to ensure that the documentation was in line with the MCA legislation and they immediately sought advice from the local MCA team regarding this.

Staff were able to tell us how they sought peoples consent. We observed one staff member seeking consent to answer the person's phone on their behalf. A staff member explained that they "always give choices, talk and discuss what would be better or not". People and relatives told us that staff sought consent to support them. One person said "they ask me, they are polite". Another told us, "they ask me, I choose what I want."

We observed staff offering people choices about what they had to eat and drink. One member of staff asked a person what they would like for their tea later on and a relative told us that staff offered their relative choices about what they had for meals. A member of staff we spoke with said "I ask them and give them choice about what they want to eat and drink. I would try to encourage them to have a balanced diet". Two people told us that staff were not always able to prepare food properly. One had needed to explain how to make the breakfast they had wanted and another had heated food in the microwave when it was not a

microwaveable product.

People were supported to access health care services promptly. One relative told us that they were contacted when their relatives catheter blocked and the service had already contacted the district nurses. Two people told us that the staff contacted the GP or district nurse when they needed them. A district nurse commented that the agency had reported pressure areas promptly and another district nurse also told us that the agency raised concerns with them promptly. We saw records which showed the service requesting visits from health professionals for a range of observations including an arm injury and someone reporting swelling and pain.

Good

Is the service caring?

Our findings

People and relatives told us that staff were kind. One relative told us that "you can tell the way they walk in and interact, my relative is comfortable with them and they have a joke". A person told us "if I need anything , they will ring and arrange it for me, they are kind". Another person said staff were "very pleasant, they chat and come in always cheerful, they make me laugh". They also said "it goes a long way to have a face with a smile, especially when you don't go out much". Another person said "the carers care and are so nice". Another relative told us that staff "talk to my relative and they seem kind". One relative explained that they were "very happy with the carers, has made a huge impact on our relative and on us as a family".

Staff knew peoples preferences and how to support them. Two members of staff told us about people that they supported and their personal preferences. For example one person had a very detailed routine and the staff member was aware and able to explain this. We observed one member of staff supporting a person with their morning routine and they were familiar and comfortable with the carer. Peoples records showed what tasks needed to be completed by staff and included whether there was a preference for a male or female carer.

The service did not always listen to peoples choices and preferences. One person told us that they had requested that they didn't want a particular member of staff and that the service had listened to them. However they had also requested that no staff visit unless they have had shadowing opportunities, but they still sent staff who had not shadowed first. The person said "if I don't want someone in here, it's our home, they should respect that". Another person said that they had "asked not to have a certain carer, but they had no-one else to send. They are listening but don't act". A relative said that they had rung and asked for particular carers not to be sent and this had not happened since". One person said that the biggest improvement the service could make would be "to listen to what we want". A member of staff told us that they tried to offer "a choice of carers people receive".

The registered manager told us about one person who had been referred for advocacy services. The advocate had not been able to attend the planned meetings and a supervisor from the agency had attended several meetings in an advocacy role. We saw that information about advocacy was included in the client handbook and the registered manager told us that they thought staff understood about advocacy.

We observed staff treating people with dignity and respect. We saw one member of staff closing the bathroom door to protect a person's privacy after supporting them to have a shower and saying "I'm just going to get your clothes". Another member of staff ensured someone was covered while they assisted them to the bathroom to support them. One person told us that staff "respect my privacy and help me with showering". Another said "they do what they are supposed to, are kind and polite". One relative told us that staff left their relative to have privacy when using a commode and that they "manage personal care respectfully, close the curtains and cover in towels when washing". Another relative told us that staff were "patient and respectful". We saw that a person's record advised staff to "leave in privacy for a while" after supporting someone to move to their commode.

People were supported to remain independent. A relative told us that staff "allow them to do bits for themselves that they can do independently". A member of staff told us that they "always try to encourage them to be independent, can you do this, would you like to try to do that. I consider the risks with tasks also". Records provided statements about how to support people but did not promote their independence. For example, one record stated "change into Pajamas and dressing gown" another stated "minimal movement in shoulders…..undress him, start from left side." Records provided statements about how to support people but did not promote their independence.

Good

Is the service responsive?

Our findings

People and relatives received a weekly rota telling them who would be visiting and when. People were not consistently informed about changes to their visits. One relative told us that "they don't let me know the night before if the visit is going to be late. The carer knew the night before but the office didn't ring me". One person told us "they don't let me know about changes and times have been erratic". Three other people told us that they were not told if visits were going to be late. We spoke with another person who had received a very late call which had caused them distress and they were not updated about the delay to the visit. Another person told us that they had cancelled visits on a few occasions either because the times were not acceptable for them, or because carers were late. Four people told us that they were told if there were changes. One said "they do let me know if they are coming late, but it's not that often". A relative also told us "if they are late they always phone to let me know". A member of staff told us that they "monitor the system to see if carers are running late, carers can run up to 30 minutes late. If carers let us know we inform the clients". Staff told us that they would ring the office if they were running late.

People and relatives told us that they were involved in reviews of their support. One person told us that they were involved in the planning of their care and that this was thorough. Another said that they had been contacted by the office to check how things were going. Another told us that they had a review once or twice a year. A relative told us that they attended review meetings "every year, to review, go through the folder and update". Another relative told us that they "had a review a couple of months ago and discussed everything". The registered manager told us they ran a weekly report showing when peoples reviews were due and told us that if a review was arranged by the Local Authority, they would send one the supervisors to attend this. We saw evidence that peoples care was reviewed, however there was not specific review documentation to demonstrate what areas had been reviewed or discussed. For example, one persons review said "small changes in the care plan, mobility slightly worse and chest infection, fluid chart in place". The registered manager did not have details of what had been discussed or updated at reviews or oversight of any themes or trends from peoples reviews.

Staff knew peoples preferences and how they liked to receive support. One person told us staff "support me in the way I like and know I'm fussy". Another person told us they "think they know how I like things done". A relative told us staff supported with the "finishing touches, brush hair and clean glasses and then spend time talking with my relative". We observed relaxed and easy going support form carers who knew the people they were supporting. One staff member told us about the care records if they went to a new person and said "I read everything there and there was enough information" to know how to support the person. However we spoke with other staff who felt that the information they received about new people was not sufficient. One explained that they would not know how to support a person to move safely from the information in their home. Another said they had not received any details about a person before their first visit. They said "there is enough information in the folder but we need the information beforehand, the office don't ring and tell us anything".

People and relatives told us that they knew how to raise any concerns or complaints if they needed to. One person told us "I would let them know what's what if I needed to". Another person told us "I did complain

last year….and the office did listen to me". A relative told us that they would ring the office with any complaints but had not needed to do so. Another relative said "They will speak to the carers if I raise a particular issue. Nothing is left hanging on". Other people and relatives told us that they would be confident to raise any concerns. We saw the complaints policy for the service which stated "complaints about our service are taken seriously, because they make it clear to use where we can improve".

Feedback was gathered from people via a questionnaire and telephone contact. The registered manager told us that when they started to provide support to a person, they completed an initial satisfaction phone call after a week and again after a month. We saw that these were scheduled in on the system for people. People told us that they fed back using the annual questionnaire. We looked at the service user satisfaction survey from 2015. It recorded that 19 people had found the staff to be thoughtful, kind and friendly. Under areas for improvement we saw that 25 people had made comments about staffing and eight of these had "commented on the need for more fluent English speakers". Eight people had also requested the service "inform clients when care is late or to be changed/is often changed". The registered manager told us that the survey results were going to be discussed at the next management meeting.

Requires Improvement

Is the service well-led?

Our findings

Quality Assurance systems at the service were not robust. Medication audits were not robust or collated which meant that the registered manager was not aware of themes in medication administration errors. Medication audits were not recorded and there was no clear evidence about whose MAR had been audited, how frequently this was done or whether any issues had been picked up. One of the directors told us that MAR errors were recorded in staff files and that reviews of staff would be more frequent if there were errors found. We raised these issues with the registered manager who promptly spoke with the supervisor and put a spreadsheet into place to capture the audit information. However there was no consistent process for frequency of staff reviews. For example, we looked at one staff file and saw that they had been observed at a visit. The review had highlighted that there were areas for improvement, however there was no follow up review booked. On another occasion, areas for improvement had resulted in a follow up observation being booked .

Peoples care reviews were not audited. We saw that reviews were not comprehensive and the registered manager was not able to see what areas had been discussed at review. The registered manager did have an overview of when reviews were due and showed us evidence of this. The service completed "satisfaction calls" to people when they first started receiving a service and we saw evidence of these. However these reviews were very short and notes recorded were minimal. For example, one review stated "spoke with (service user), extremely happy with the service". Another said "pleased with care receiving". Another said "phoned and refused to talk" and another "unable to contact on telephone, did not answer". Full reviews of care were recorded in a similar way with very minimal notes recorded. The registered manager told us that reviews covered all areas, but acknowledged that this was not currently recorded or audited.

People and relatives told us that they were able to speak to the office easily when they needed to. One person told us that the office was "easy to contact and ok on the phone". A relative told us that the office "all know my relative and me, so they communicate well". Another relative said that staff "know my name and (they are) easy to contact. The out of hours works well". Another said that the office were "very helpful, always able to get hold of them, even at funny times". The out of hours cover for the service was shared with another branch of the service. People and relatives told us that they were always able to get through to someone outside office hours when they needed to. Staff also told us that they were able to speak to an on call member of staff when needed.

The registered manager told us that they "do not take staff unless we feel English skills are sufficient". They acknowledged that they had had "a few people highlighting communication issues and when addressed we have found people would prefer and English carer". They advised us that they had approximately 50% whom English was not their first language. The registered manager told us that they had put staff forward to undertake English classes at a local library to try to address some of the communication issues. The registered manager was aware of peoples feedback around communication with staff for whom English was not their first language, however these issues had not been effectively managed.

This was a breach of regulation 17(1) (2)(a)(b)(e) of the Health and Social Care Act 2008(Regulated Activities)

Regulations 2014.

Communication between staff was not always good. The registered manager told us that the service did not hold any regular staff meetings at the present time. However they advised they were looking at "how we can set up meetings which staff will attend". There was a meeting for the supervisors, roster and management team and we saw minutes of these. Areas covered included quality improvement for care plans, robust completion of records and timely completion of initial care needs assessments with people. Staff received a regular newsletter from the service and the registered manager told us that they attached relevant policies with these for staff to read. We saw two newsletters from April 2016 which included contact details, compliments, complaints and annual leave availability, but did not include any practice discussions or updates. The registered manager showed us evidence that a variety of policies were sent to staff with the regular newsletters. These included information about food hygiene, falls, slips and trips and medication administration support procedures. The most recent policy we were shown had been sent out in June 2015, but the registered manager did not show us any more recent evidence of information being sent out to staff. A staff member told us that the newsletters "let us know we are doing a good job".

We spoke with one staff member who told us that "staff do communicate with each other" and another told us they were "very happy with this company, (they) give me work and support me". However a member of staff told us that staff could "be quite rude" when discussing additional shift cover or travel times. Another member of staff told us about member of staff who they felt was quite rude when they spoke with them. Another member of staff told us that they were not happy with their working shift pattern but were not sure whether the office would listen to them. The registered manager told us that they had an open door policy and told us that if staff were "concerned they can ring at any time or email in".

The registered manager told us that they had supervision annually unless they required it sooner. They also said that they had a management meeting monthly where the service improvement plan was considered and discussed. This meeting was also used to discuss and plan actions required at the service. The registered manager showed us that actions included allocating outstanding client reviews and password protecting staffing rosters.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to individuals were not managed safely by the service. Medicines were not recorded correctly on Medicine Administration Records (MAR).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance audits were not comprehensive and did not provide an overview of themes or trends at the service. Issues with communication had not been managed effectively.