Triangle Community Services Limited

London East

Inspection report

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Website: www.triangle.care

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 8 January 2018 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

London East is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. At the time of the inspection it was providing a service to 20 people.

The service did have a registered manager however the person had been promoted elsewhere within the company. The service had a different member of staff acting in the role of manager with day to day responsibility for running the service. The manager had started the process to apply for the role of 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.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions Safe, Responsive, Effective and Well-led to at least good. The service was last inspected in November 2016 when we identified breaches of regulations regarding notifications of other incidents, need for consent, staffing, safe care and treatment and good governance. We asked the provider to take action to make improvements. Although the provider had addressed specific concerns around notifications of other incidents, need for consent and staffing, the breaches of regulations continued on this inspection in relation to safe care and treatment and good governance. We also found on this inspection a breach of regulation for person centred care.

We found care plans lacked detail regarding the specific nature of the support people needed and people's preferences were not always clearly captured.

Risks people faced had been identified, but the measures in place to mitigate them were not clear. Medicines records for people who received medicines on a 'when required' basis (PRN) were unclear. PRN medicines are to be taken as needed instead of on a regular dosing schedule. The governance and audit arrangements of PRN medicines had failed to identify or address the range of concerns found during the

inspection.

Staff received regular supervision and records showed staff were able to give feedback and suggestions about how the service should be run. However it was not always clear senior staff provided support and guidance following feedback received in supervision. We have made a recommendation about supervision.

The service was recording complaints however outcomes and learning points identified had not been recorded. We have made a recommendation about the management of complaints.

Staff undertook training to help support them to provide effective care. Staff had a good understanding of the Mental Capacity Act 2005 (MCA). MCA is legislation protecting people who are unable to make decisions for themselves.

People and their relatives told us they were supported with choosing what they wanted to eat and drink with the support of staff.

People's cultural and religious needs were respected during care planning and delivery. Discussions with staff members demonstrated they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service.

People who used the service and their relatives were positive about the staff and told us they were caring. People and their relatives were involved in the planning of their care.

Staff, people and their relatives felt the manager and the office staff were approachable and accessible.

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

The overall rating for the service is Requires Improvement. This is the second consecutive time the service has been rated Requires Improvement.

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 always safe. Information for staff about how to mitigate risks people faced was not always clear.

Information about how to support people to take their medicines was not always clear.

Staff were able to explain what constituted abuse and the action they would take to escalate concerns about people's wellbeing.

Staff were recruited appropriately and adequate numbers were on duty to meet people's needs.

Is the service effective?

Good

The service was effective. Staff undertook regular training and annual appraisals. Staff received regular supervision however it was not always clear senior staff provided support and guidance following feedback received in supervision.

The provider met the requirements of the Mental Capacity Act (2005).

Staff were aware of people's dietary preferences.

The service worked with other services and healthcare professionals involved in people's support.

People were supported to have their routine healthcare needs met.

Is the service caring?

Good

The service was caring. People and their relatives told us they were well treated and the staff were caring. People could make choices about how they wanted to be supported and staff listened to what they had to say.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's

right to privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans lacked detail regarding the specific nature of the support people needed and people's preferences were not always clearly captured.

Complaints were recorded however outcomes and learning points identified had not been recorded. People and their relatives knew how to make a complaint.

People's cultural and religious needs were respected. Staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service.

Is the service well-led?

Requires Improvement

The service was not always well-led. Quality assurance audits were not always identifying problems with the service provision.

Staff told us they found the manager approachable.

London East

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.

This inspection took place on 8 January 2018 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. The inspection team consisted of two inspectors.

Before we visited the service we checked the information we held about the service and the service provider. This included any notifications and safeguarding alerts. A notification is information about important events which the service is required to send us by law. The inspection was informed by feedback from professionals which included the local borough contracts and commissioning team that had placed people at the home, the local borough safeguarding team, and local clinical commissioning groups. We reviewed the information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with the manager, one team leader, one client coordinator, and three care workers. We looked at five care files, staff duty rosters, six staff files which included supervision records and recruitment records, a range of audits, minutes for various meetings, two medicines records, accidents and incidents, training information, policies and procedures, and complaint information. After the inspection we spoke with four people who used the service and five relatives.

Requires Improvement

Our findings

At the last inspection in November 2016 we found the service was not safe and we had identified breaches of regulations regarding safe care and treatment and staffing. At this inspection we found progress had been made with regard to staffing. However we found the provider had failed to address concerns regarding safe care and treatment in regard to risk assessments. Also people were not always effectively supported to receive their medicines in a safe way.

People were identified as requiring support with moving and handling. However, there was insufficient information recorded for care staff to ensure they supported people in a safe way. For example, one person was identified as being unable to walk. The risk assessment on mobility had identified the person needed support and stated, "[Person] requires assistance for all tasks." The risk assessment listed the equipment needed to support this person was a ceiling hoist, slide sheet and shower chair. The risk assessment and care records gave no guidance about how to use this equipment and what tasks the person needed support with. This meant it was unclear from the information documented how staff could mitigate risks associated with moving and handling to make this person safe. In a second example, one person was identified as bedbound. The risk assessment stated, "[Person] needs two carers to assist with any form of movement or transfer as [person] is totally bedbound." The risk assessment listed the equipment to support this person was a hoist and sling. The risk assessment and care records gave no guidance how to use this equipment and what risks there would be to the person and staff.

Risks people faced due to chronic health conditions were not well managed. For example, one person was identified as being diagnosed with type 2 insulin dependent diabetes. The risk assessment stated, "[Person] is bedbound and requires insulin at all times." Under risks identified and actions taken the assessor stated "district nurse administers." The risk assessment and care plan gave no other guidance with the risks associated with type 2 insulin dependent diabetes, how to monitor for signs of high or low blood sugar levels, or how the risks could be mitigated to ensure the person's safety.

Another person had been identified as having behaving behaviour that could challenge the service as they had a history of verbal and physical aggression. Under the 'actions to address this behaviour' section of the risk assessment the provider had only stated, "When [person] is in his bad moods due to his condition" and "when [person] is feeling threatened and insecure;" and not given any detail of action to be taken. It was therefore unclear from the information documented how staff could support this person when they were physical and verbally aggressive. This meant people were at risk of harming themselves or others because risks were not appropriately assessed.

People were at risk of not receiving their medicines safely. Medicines records were not clear for people who received 'when required' (PRN) medicines. PRN medicines are to be taken as needed instead of on a regular dosing schedule. For example, one medicine record showed a person was prescribed a laxative and it was recorded to be taken twice a day. However, the manager told us this was a PRN medicine but no further guidance was in place. The service had a PRN protocol template as part of the provider's medicine policy which should be used to provide clear guidance for staff about how and when the medicine should be administered. However care records showed it was not being completed for the care records we looked at. This meant people were at risk of not receiving the medicine they require or receiving an overdose because the information was not being completed.

Medicines risk assessments were completed for people who were supported with medicines administration. However these were insufficient and did not inform staff of the individual support needs and risks faced by people they supported to take medicines. For example, one medicines risk assessment for a person who was supported with medicines indicated the person had answered yes for the question 'does the service user understand how to take their prescribed medication?' However it was not clear if this meant if they could administer medicines themselves. The medication risk assessment gave no specific instructions, outcomes and risks involved. This meant people continued to be at risk of unsafe care and treatment as risks had not been appropriately identified or mitigated against.

The above issues with medicines management and risk assessments are a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Through our discussions with the registered manager, staff, relatives and people who used the service, we found there were enough staff to meet the needs of people who used the service. Staffing levels were determined by the number of people using the service and their needs, and could be adjusted accordingly. The manager told us they had looked at the rota and allocated less shifts to care staff so they were able to travel between visits and be on time. People who used the service and their relatives told us the care worker visit times had improved. One person said, "Mostly [staff] come on time. The office is getting better at phoning if they are running late. It's improved. There was a time when they were often late. Now it has got better." Another person said, "Yes they [staff] always come." A relative said, "Most of the time the two carers turn up at the same time. If they are slightly late we will wait and they do call to tell us that they are on their way. Due to traffic etc" A staff member told us, "Double ups (two care staff providing care) I find perfect. We turn up at the same time." Another staff member said, "No issues with double ups."

A team of three care coordinators planned rotas one week in advance. The manager, team leader and coordinators had introduced new working practices in 2017 to help reduce care staff travel time between home visits. For example, the coordinator team used a 'patch' system to try and keep staff in a restricted geographic area. All office-based staff undertook the same care training as care workers. This meant they could respond rapidly to any unpredicted staffing issues and provide support themselves. In addition office-based staff led the 24-hour on-call service and their training meant they could deliver care including mobilising and personal care if needed.

Although the coordination team used an electronic system to plan home visits, they did not routinely monitor this system. In addition, there was no sign-in system for care staff with the office which is contrary to good practice. This meant the senior and office teams were only aware of late or missed home calls if someone called to tell them. We spoke with the team leader about this who said they reinforced to all care staff the importance of letting the office team know as soon as they encountered a problem or delay.

People and their relatives told us they felt the service was safe. One person told us, "I do feel safe in my

home when carers come." Another person said, "I feel very safe."

There was a safeguarding policy in place which made clear the provider's responsibility to report any allegations of abuse to the local authority and the Care Quality Commission. Records showed staff had completed training in safeguarding adults. Staff were able to tell us about the signs of abuse, and how they would report their concerns and including those agencies outside of the organisation, such as the local authority safeguarding team. One member of staff said, "I would report it to the manager. There is a phone number to call for whistleblowing." Another staff member said, "I would report to my manager or team leader. If nothing is done then to the CQC." The service had a whistleblowing procedure in place and staff were aware of their rights and responsibilities with regard to whistleblowing. This meant the provider ensured people were protected from avoidable harm and abuse.

Records showed there had been one safeguarding incident since the last inspection. The manager was able to describe the actions they had taken when the incident had occurred which included reporting it to the Care Quality Commission (CQC) and the local authority. This meant that the provider reported safeguarding concerns appropriately.

Accident and incident policies were in place. Accidents and incidents were documented and recorded and we saw instances of this. Staff had reported one incident in the 12 months leading up to our inspection. The incident was a missed dose of prescribed medicine with a person who refused to take it. The senior care team believed the person needed a more thorough mental capacity assessment as they had noticed deterioration in mental function. We found the team had liaised with multidisciplinary colleagues, including the community mental health team, to coordinate this individual's care.

The provider followed safe recruitment practices. Staff recruitment records showed relevant checks had been completed before staff worked unsupervised at the service. We saw completed application forms, proof of identity, references and Disclosure and Barring Service (DBS) checks. The DBS is a national agency that holds information about criminal records. This meant the provider had done all that was reasonable to ensure people were suited to working in the caring profession.

Records showed staff had completed training on infection control. Staff had access to policies and guidance on infection control. Staff told us supplies of protective clothing were available which included gloves, aprons and shoe covers. People who used the service and relatives told us care staff wore protective clothing when providing care. One staff member told us, "We make sure we wash our hands and take our gloves with us." Another staff member said, "We wear protective aprons and gloves."

Good

Our findings

At the last inspection in November 2016 we found staff did not receive annual appraisals in order to ensure they understood what was expected of them and staff did not always follow the legal requirements in relation to the Mental Capacity Act 2005. At this inspection we found the service was now meeting those regulations.

Staff underwent an annual appraisal and as of November 2017 all staff were up to date. In addition, a new six weekly mentoring scheme ensured staff had regular time with experienced colleagues to review their work and discuss individual cases or concerns. This contributed to their competence and performance and senior staff told us it also supported retention of staff. The senior team monitored supervision and training needs through a monthly branch review that enabled them to identify gaps in training. For example in November 2017 the team carried out 25 one-to-one supervisions and noted 34 were outstanding to be carried forward. In addition 90% of the care team attended training to help them provide care for people with unpredictable behaviour or behaviour that interrupted care.

All staff undertook an induction on joining the organisation as well as after an extended period of absence. A designated team of senior care and operations staff delivered induction training, which included shadowing time with experienced staff. Records confirmed this.

The service had a programme of mandatory training that all staff were expected to complete. Regular refresher training was provided and the senior team monitored this through monthly tracking. For example in November 2017 care staff underwent moving and handling refresher training. The provider had suspended care certificate training for care staff and introduced alternative training in November 2017 as a replacement. The care certificate is a recognised qualification that ensures that staff have the fundamental knowledge and skills required to work in a care setting. The alternative training to the care certificate included nine core modules relevant to the care provided including food safety and hygiene, infection prevention and control specific to health and social care and medication awareness. The provider used the new training package to form its mandatory training programme for staff. One relative said, "They [staff] seem to go on courses quite often." Another relative told us, "They [staff] were trained by [occupational therapist] when we changed hoist." A third relative said, "They [staff] do have dementia training." A staff member said, "They give us training every year." A second staff member told us, "It's good. The training is on our rota. We have on-going training."

Care staff received regular supervision from the team leader. Records showed staff were able to give

feedback and suggestions and the team leader encouraged them to identify their achievements and areas for improvement. They also used supervision time to discuss the needs of the people they provided care for. One staff member told us, "It is quarterly. [We discuss] what is going good and bad." Another staff member said, "We come in and talk about what is happening with the service users and anything we need to raise. They cover anything we can do better." However it was not always evident the senior team provided support and guidance where needed. For example, supervision records showed one member of staff fed back that a person they cared for wandered or paced a lot during the night and they were unsure what to do. The only action noted in the supervision was to keep the office informed. This meant it was not evident the senior team had investigated the person's condition appropriately or provided additional support and guidance to the member of staff.

Supervision records showed communication between the office team and the care team was often inconsistent. For example, one theme in supervisions was the lack of work hours available and lack of consistency in being matched to people. Staff noted they were reassigned to people if they took time off for a holiday, which caused disruption to people and their routine. We saw one care worker raised this as a concern consistently for the previous two years but there was no documented resolution or feedback.

We recommend that the service seek support and training for the senior staff, in relation to providing staff supervision, to help them carry out their role effectively.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. Domiciliary care services must apply to the Court of Protection for legal authorisation to deprive a person of their liberty.

We found that staff were monitoring individuals for any capacity issues and where a decision had to be made for the person, this was done following a best interests process and involving people close to the person who knew them well and acted as their advocate. Records showed where people had legally appointed decision makers. One staff member told us, "You have to find out what [people who used the service] want." The manager told us, "We have to ensure the people have got mental capacity. If they don't we have to get an appointed person. If no appointee we have to make the best interest for that person with the support of social services." A relative said, "[Staff] do [ask for consent] and they tell [relative] we are going to wash you or turn you." Another relative told us, "Yes, they [staff] ask for consent. My [relative] will ask them to wait until he is ready." This meant the service followed best practice in order to support people to make decisions, act in people's best interests and protect people's rights.

People and their relatives told us staff were very good and supportive. One person said, "Yes they [staff] help me. Make a shower, make my bed, and help come down [stairs]. I am very pleased." A relative told us, "As we have the same carers they know [relative] very well. I can leave them with my [relative] and not worry."

Before admission to the service a pre-admission assessment was undertaken to assess whether the service could meet the person's needs. The pre-admission assessment looked at people's physical, mental health, communication and social needs. A relative told us, "Yes I had input when we first used the agency."

People and their relatives told us they were well supported with meal preparation. One person said, "Yes, they [staff] are very good at cooking." A second person told us, "[Staff member] cooks for me. I tell her what I want. [Staff member] very good cooking if you show her what to do." A relative said, "They [staff] do all the cooking and they know what [relative] likes to eat." People and their relatives told us care staff knew people's preferences with food however care plans contained minimal information about people's food preferences.

Staff were aware of what action to take if people were unwell or had an accident. They told us they would contact people's GP or phone for an ambulance as necessary. A member of staff told us, "I would monitor [people who used the service]. I would call the office and ambulance." We saw that care plans included contact details of GPs, pharmacies and next of kin. One person told us, "[Staff member] does everything. [Staff member] makes appointments for me. [Staff member] books transport for me for hospital appointments. Yesterday [staff member] called the hospital." Another person said, "[Staff member] called the GP." This meant that people were supported by staff to maintain their health and wellbeing.

The manager also told us about their involvement with other agencies and stated, "Always on the phone to people I work with. We work closely with discharge planning team, social services, work with commissioners, nurses with the GP and physios."

Good

Our findings

People and their relatives told us the staff were caring. One person when asked if staff were caring told us, "I believe so. They are usually fairly good. They are understanding of my issues." Another person said, "I get on well with [staff member]. I miss [staff member] when [staff member] goes." A third person said, "Yes of course. They [staff] love me. They talk to me." A relative said, "Yes they are [caring]. We are like a family. We don't feel like it's a stranger coming to the house. We have no problem leaving the house." Another relative told us, "Very caring. Very sensitive to [relative's] needs. They understand what [relative] is trying to say."

Staff knew the people they were supporting. Staff we spoke with were able to tell us about people's life histories, their interests and their preferences. Staff spoke in a compassionate way about the people they supported and told us they enjoyed working with their clients. One staff member said, "They [people who used the service] are becoming more like a family." Another staff member told us, "I get along with [them] well. It's very friendly. I try to communicate with them so they understand me and I get to know them."

The service looked at matching staff with people they would be most suited to work with. The provider sent us in the Provider Information Return (PIR) before the inspection. The PIR stated, "We try to match them to staff by way of using both profiles to match staff to a service user." People and their relatives told us they felt staff allocated to them meet their needs.

People and their relatives were actively involved in making decisions about the care and support provided. Care plans were reviewed regularly with input from people and their relatives. Records confirmed this. One person said, "[The care plan] is reviewed at least once a year." One relative told us, "We had to update [the care plan] recently." Another relative said, "Someone came out recently to review it." A third relative, "Every six months [the care plan is reviewed]. "

People's dignity was respected. Staff we spoke with gave examples how they respect people's privacy. One staff member told us, "You just don't go in. You knock and wait for a response. You go with a greeting. You just don't start working." Another staff member said, "We shut the door giving personal care. Use a towel to keep them warm." A relative said, "Of course they [staff] do. They close the door when they look after [relative]. They cover [relative] and they close the curtains." A second relative told us, "Yes they [staff] do. The door is always closed. They will ask before they remove [relative's] pad. They are gentle and supportive."

People were supported to maintain their independence. Staff told us the supported people to manage as much of their care as they could themselves. One staff member said, "[Person] can do some things herself

like clean her face. Sometimes she wants to brush her teeth."

Requires Improvement

Our findings

All the care files we looked at had similar phrases and information about the care to be provided, with limited personal information. People had an assessment before receiving care and support. Prior to the assessment, the local authority or the clinical commissioning group provided an initial assessment. A senior worker visited the person to complete an assessment following a referral from the local authority or the clinical commissioning group. Following this a care plan was developed. However, we found that people did not have assessments that were person centred.

People's care plans were task focussed, for example, where people needed help with washing and dressing this was recorded but they did not include the person's preferences about how this was completed. Recorded decisions about care planning did not include people's likes and dislikes. We found that people's care plans did not provide details of people's views about how they wanted to be cared for.

For example, one care plan stated that a person was diagnosed with diabetes in the medical history. However the care plan gave no guidance on how this person could be supported by the care staff. In another example, one person had been assessed as needing support with meal preparation. The care plan stated, "Assist with meal preparation." However no information was given to indicate what the person's preferences, likes/dislikes with meal preparation would be. A third person had been assessed with needing support with communication. The care plan stated, "[Person] does not communicate and [relative] understands very small amount of English so it would be advised when making appointments, one of the children present." The care plan gave no other information how this person could be supported with communicating their needs.

The provider sent us in the Provider Information Return (PIR) before the inspection. The PIR stated, "The London team is a very busy team due to the fact that the End of Life contracts requires us to respond and act immediately. Patients are being discharged or is sent home from hospital and we receive a call to provide a service immediately or the next day. The team must respond immediately to arrange and put a service in place." The manager also told us a large number of people referred to the service were reaching their end of life. Records showed people had an assessment before coming to the service who were reaching their end of life and under a palliative care team. However care plans did not reflect end of life preferences and wishes. The service used a template that covered different aspects of care however end of life was not part of the planning process. The manager told us and we saw records to show that this had been highlighted as a concern and an action plan was in place to address this by the end of January 2018. This meant that care was not tailored to the requirements of each individual person and could result in poor standards of care

being given.

The above issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the care plans lacked detail regarding end of life care, the provider did have a policy on end of life for people who used the service. The policy was appropriate for people who used the service. The policy covered such topics as privacy and dignity, cultural and religious preferences and working in partnership with health care professionals. Staff we spoke with expressed how people with end of life would be supported. One staff member said, "I got the training [end of life]. It's very emotional and difficult. You have to support the family as well. When someone dies they do counselling here and give us time off to bounce back." Another staff member told us, "It can be very emotional. Need to be sympathetic about the situation. We talk to [people who used the service] even if they don't talk back." A third staff member said, "The main thing is to make them comfortable. We try to communicate with them."

People told us they enjoyed the service provided. Relatives felt the care and support was responsive to their relative's needs. One person told us, "[Staff member] looked after my [relative] before [they] died. That's why [staff member] knows me. [Staff member] has been here nearly four years." A relative said, "They [staff] are cordial. They are very good."

The service had received three formal complaints in the last 12 months. All three complaints related to staffing issues including in relation to a lack of understanding of care from staff, rushed care, missed calls and the attitude of some individuals. For example, one person said their planned double-up calls were often missed and carried out by a single member of staff. Also a relative raised concerns that staff sat down using their mobile phones during home visits rather than providing care. In each case the manager acknowledged to the complaint and in one case they carried out a home visit themselves. For example, the manager had spoken with staff about improving the standard of care and told the person to contact them again if things did not improve. However none of the complaints had been documented as investigated or resolved. There were no learning outcomes recorded from any of the complaints that led to improvements in care or staff training.

We asked the team leader about complaints. They told us they routinely carried out home visits and spot checks if a person or relative raised a concern. The team leader also said they provided one-to-one support with care staff to enable them to better meet individual needs if a person reported a concern or provided feedback. As a result of feedback the senior team had provided access to the out of hour's on-call service for people and their relatives. This meant if a planned home call was late or there was an issue the care staff could not resolve, people had a contact to escalate the problem.

Members of the office team who provided the on-call service met regularly to discuss feedback from people and staff and the running of the service. Records confirmed this. This helped the team to identify on-going issues or problems as well as to highlight areas of good practice and compliments.

We recommend that the service seek advice and guidance from a reputable source, about the management of and learning from complaints.

Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people (LGBT) could feel accepted and welcomed in the service. The staff member told us, "I would treat them like any other person. I'm here to provide a service and not make them feel they are doing anything wrong. I respect their lifestyle." Another staff member told us, "They are a

person. You respect their rights."

Requires Improvement

Our findings

At the last inspection in November 2016 we found systems to assess, monitor and improve the service were in place. However, these were not always thorough in identifying and addressing shortfalls. At this inspection we found that not enough improvements had been made.

During this inspection, records showed the provider had systems in place to regularly assess and monitor the quality of care people received. The purpose of providers having such systems in place is to identify areas of the service which require improvement and drive forward the quality and safety of the services provided. The systems in place included obtaining people's feedback, audits of people's care records and medicine administration records, external audits and conducting unannounced spot checks to observe staff delivering care to people.

The service conducted an annual survey which they sent to people who used the service and their relatives. The last survey sent out was in September 2017. Although most of the feedback was positive, a significant number of respondents had indicated they had issues regarding care workers punctuality, what to do if the care worker did not arrive on time, being notified if a different care worker was being allocated, and the response when contacting the out of office number. We asked the manager if there was any analysis of the survey and an action plan. The manager told us there was not. This meant there was no effective system in place to respond to feedback and to use it to improve the quality of service.

The service had a number of quality assurance systems in place that had identified concerns. However it was not always evident these concerns had been addressed. For example, an internal audit was conducted in June 2017. The audit had looked at the concerns raised from the CQC inspection in November 2016 which included risk assessments, staffing, appraisals, person centred care plans and quality assurance. The internal audit stated, "All risk assessments needed were in place, correctly completed and also included a re-assessment." Also, the director of the service conducted a bi-monthly audit. The audit for November 2017 stated, "Care plans were improved, with more guidance and personalised details on risk assessment and medication instructions." However this was not reflected during our inspection which showed risk assessments were not detailed, care plans were not person-centred and medicines management was not robust.

This meant the audit systems were not sufficiently robust to identify and address the issues we found at our inspection. The auditing systems had not identified the discrepancies we found in relation to the recording of people's medicines, risk assessments, complaint outcomes and learning, and care plans that were not

personalised. This meant that systems were not effectively operated to monitor and improve the quality and safety of the services provided to people.

The above issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulation 2014.

People who used the service and their relatives told us they knew who was the manager was and they thought the service was well managed. One person said, "[Manager] is the manager. Very good." People and their relatives were very positive about the office staff. One person said about the office staff, "They are quite friendly." A relative told us, "They [office staff] are approachable and they visit us." Another relative said, "Yes they are friendly and they know me by name. They even recognize my voice."

The service did have a registered manager however the person had been promoted within the company. The service had a manager who was acting in the role who had started the process of applying for the role of registered manager. Staff told us the manager was approachable. One staff member told us, "If you need to raise something you can call and talk to [manager]. She does help." Another staff member said, "She listens to you without shutting you down." A third staff member told us, "You can talk to her."

Records demonstrated that the manager and the office staff carried out spot checks on staff to ensure they provided care in line with good practice. One relative told us, "They [office staff] come and ask us questions of how the carers are doing. They do spot checks of the carers. Every six months." Another relative said, "One of the managers did a spot check on one of the workers." A staff member told us, "They [office staff] do spot checks." Another staff member said, "I had a spot check on a waking night. They check if the person is being looked after properly."

A senior office member told us they routinely carried out home visits and spot checks if a person or relative raised a concern. The team leader also said they provided one-to-one support with care staff to enable them to better meet individual needs if a person reported a concern or provided feedback. As a result of feedback the senior team had provided access to the out of hour's on-call service for people and their relatives. This meant if a planned home call was late or there was an issue the care staff could not resolve people had a contact to escalate the problem.

Staff meetings for care staff and office staff were held regularly. Minutes of the care worker meetings showed there was regular discussion about people who used the service, training, medicine records, record keeping and lateness. One staff member told us, "They have staff meetings. You learn from other carers and managers." Another staff member said, "They talk about what is going on and what care staff can do to change." The senior team used a monthly branch review to monitor incidents, near misses, safeguarding cases, medicines errors and changes to people's risk assessments. This meant staff had the opportunity to share information with all team members.

There were policies and procedures to ensure staff had the appropriate guidance, staff confirmed they could access the information if required. The policies and procedures were reviewed and up to date to ensure the information was current and appropriate.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans did not include details of people's needs and preferences and how they should be met. Regulation 9(3)(a)(b)

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for service users as the registered person did not always assess the risks to the health and wellbeing of service users and did not always do all that was reasonably practicable to mitigate any risks and did not ensure the proper and safe management of medicines. Regulation 12 (1) (2) (a) (b) (g)

The enforcement action we took:

warning notice

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not established and operated effectively to assess, monitor and improve the quality and safety of the services provided. Regulation 17 (1) (2) (a) (b) (c)

The enforcement action we took:

warning notice