Hereson House Limited

One Step South Domiciliary Care Agency

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 29 and 30 June and 1 July 2016, and was an announced inspection. The registered manager was given 48 hours' notice of the inspection. At the previous inspection on 14 and 15 March 2015 a breach for records relating to medicines management, risk management and care planning was found.

One Step South Domiciliary Care Agency provides care and support to adults in their own homes. The service is provided mainly to people who have a learning disability, some of whom live on their own and some shared with other people using the service. At the time of this inspection there were 14 people receiving support with their personal care. The service provided one to one support hours to people as well as providing a live-in service for 24 hours a day to support people. The service is delivered in the areas of West Norwood, Streatham, Lambeth, Woking, Guildford and Kent.

The service is run by a registered manager, who was registered in August 2015. 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.

Most risks associated with people's care and support had been identified, but not all. Some risks lacked sufficient guidance to keep the person safe. One piece of equipment had not been serviced within recommended timescales to ensure it remained safe.

People were involved in the initial assessment and the planning of their initial care and support and some had chosen to involve their relatives as well. However care plans still required further information to ensure people received care and support consistently and according to their wishes. People told us their independence was encouraged wherever possible, but this was not always supported by the care plan.

The provider had undertaken some work to address the shortfalls identified at the previous inspection and audits had identified the shortfalls found during this inspection. However effective and timely action had not been taken to ensure compliance. There had been changes to senior staff in the last 12 months and this had impacted on the service people received. People felt the communication with senior staff and management was not good.

People had their needs met by sufficient numbers of staff, but people did not always receive a service from a team of regular staff as staff turnover was high. New staff underwent an induction programme, which included relevant training courses and shadowing experienced staff, until they were competent to work on their own. Staff received training appropriate to their role, although refresher training was not undertaken in a timely way to ensure staffs knowledge remained up to date.

People were not always supported to maintain good health and attend appointments and check-ups. People told us their consent was gained at each visit and they were supported to make their own decisions and choices. However care plans were not always clear about people's capacity to make their own decisions or how staff had come to judgments about people's capacity to make a certain decision.

People felt staff were kind and caring. However we identified two examples of practice that did not uphold people's privacy and dignity.

People and their relatives did not have opportunities to provide feedback about the service they received in order that this could be used to drive improvements.

Some people were subject to an order of the Court of Protection and some people chose to be supported by family members when making decisions. Staff had received training on the Mental Capacity Act (MCA) 2005. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The registered manager understood this process.

People felt safe using the service and when staff were in their homes. The service had safeguarding procedures in place and staff had received training in these. Staff demonstrated an understanding of what constituted abuse and how to report any concerns in order to keep people safe.

People had confidence in the new senior staff and felt they would turn things around and improvements would be made.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this 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

The service was not always safe.

Most risks associated with people's care had been identified, but there was not always sufficient guidance about how to keep people safe.

People received their medicines safely and when they should. Guidance about medicines prescribed 'as required' was in place in all but one case.

People's needs were met by sufficient numbers of staff and these were kept under review.

People were protected by robust recruitment processes.

Is the service effective?

Requires Improvement

The service was not always effective.

People received care and support from supported staff, but there were shortfalls in staff receiving refresher training to ensure their knowledge remained up to date.

People were not always supported to maintain good health and attend appointments.

People's care and support was not always delivered by regular staff as the turnover of staff was high.

Staff encouraged people to make their own decisions and choices, but people's capacity to make decisions was not always clear in care plans.

Is the service caring?

Requires Improvement

The service was not always caring.

During the inspection people were treated with dignity and respect and staff adopted a kind and caring approach. However two examples of this not happening were brought to our attention.

People felt relaxed in the company of staff and people said they were listened to by staff who acted on what they said.

People felt staff supported them to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans did not reflect all the detail of their personal care routines, their wishes and preferences or what they could do for themselves, to ensure consistent care and support.

People had not had opportunities to provide feedback about the service they received.

People were not socially isolated as they accessed the community regularly.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were audits and systems in place to monitor the service people received. However action was not always effective or taken in a timely way to address identified shortfalls to ensure compliance.

There had been changes to senior staff which had impacted on the service people received. People felt the communication within the service was not good.

During the inspection there was an open culture within the service and people felt the new senior staff would drive the improvements required.

One Step South Domiciliary Care Agency

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 checked 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 29 and 30 June and 1 July 2016 and was announced with 48 hours' notice. The inspection carried out by one inspector.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to the inspection we reviewed this and other information, such as the previous inspection report, we held about the service, we looked at notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

During the inspection we reviewed people's records and a variety of documents. These included five people's care plans and risk assessments, three staff recruitment files, staff training, rotas, medicine and quality assurance records and staff surveys results.

We spoke with three people who were using the service, which we visited in their own homes; we spoke with three relatives, the registered manager and seven members of staff.

Before the inspection we sent survey to people who used the service, relatives, staff and professionals who had had involvement with the service. We received feedback from six people who used the service, eight relatives and one member of staff.

Before and following the inspection we contacted four health and social care professionals who had had

contact with the service and received feedback from two.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe when staff were in their homes and when they provided care and support.

At the previous inspection we found that risks associated with people's care and support had in most cases been identified, but there was not sufficient guidance in place to fully reduce those risks. We found this continued to be the case at this inspection. One person had developed a blister as a result of using a hot water bottle. Incident report records showed that staff had taken action to reduce the risk of this happening again by introducing that the hot water bottle had a proper cover and was wrapped in a towel. However no risk assessment was put in place to ensure this action was always adopted by staff to keep the person safe. Once highlighted a risk assessment was put in place by senior staff and a copy sent to the inspector. One person that had recently started to use the service had diabetes. They told us their blood sugar levels were erratic due to medical treatment they were receiving, although the risks associated with this had not been assessed and there was no guidance in place to advise staff of the signs and symptoms should they become unwell due to their diabetes and what action to take should to keep this person in good health. Again once this was highlighted to senior staff a risk assessment and guidance was put in place and a copy sent to the inspector. In another case a person had a history of behaviour that might challenge others, but guidance was insufficient in how staff should manage this consistently and safely and also what they should do if their first approach did not work, in order to the person safe. There was an updated care plan in place, but staff told us this required further adjustments following training. The registered manager told us that the adjustments had been handwritten by senior staff in conjunction with a health professional, but these had not been typed up and a copy of the handwritten guidance was not available to staff for reference at the time of the inspection.

Another person's moving and handling risk assessment continued not to contain guidance specific to them. It talked about some sling straps may need to be crossed, but did not inform staff if this was the case for this person, which if the sling was not put on properly would be a safety risk to the individual. Staff told us this person had three different types of slings and they were all used in different situations, such as when bathing, toileting or moving from bed to chair. However this detail was also not included in the risk assessment. This meant that the guidance was unclear about which sling and exactly how to put the sling on leaving a risk this may not be done properly or safely.

Staff told us that visual checks were regularly undertaken on any equipment used, such as hoists and servicing arrangements were in place. However we found that one hoist had not been serviced within the recommended timescale. The hoist should have been serviced on 1 March 2016, although staff told us this was booked to be serviced the following week.

The provider had failed to do all that was reasonably possible to mitigate risks to people's health and safety. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they had a risk assessment in place in the event of emergencies. This included bad weather and measures, such as using staff that lived locally or sharing staff with another

nearby service, to ensure people would still be supported and kept safe.

At the previous inspection we found shortfalls in the medicines records and the provider had taken steps to address the shortfalls identified during that inspection. There was a clear medicines policy in place. The majority of staff had received up to date training in the management of medicines and their knowledge was checked following training.

Where people were prescribed medicines on a 'when required' or 'as directed' basis, for example, to manage skin conditions, there was in all but one case clear individual guidance for staff on the circumstances in which these medicines or topical medicines were to be used safely and when they should seek professional advice on their continued use.

Medication Administration Records (MAR) charts were in place where staff administered people's medicines. Medication Administration Records charts reflected that medicines had been administered or a code entered as to the reason they were not.

People were protected by robust recruitment procedures. We looked at three recruitment files of staff that had been recently recruited. Recruitment records included the required pre-employment checks to make sure staff were suitable and of good character.

People had their needs met by sufficient numbers of staff. Staffing levels were in most cases provided in line with the support hours contracted with the local authority. Some people were supported 24 hours a day with additional one to one support hours and others just received one to one support hours. Senior staff were responsible for covering the rotas taking into account people's support needs. The service had staff employed on permanent contracted hours and staff on flexi contracts (staff that worked as and when required). In addition some people's support hours were permanently covered by an outside agency. There was also addition agency use to cover vacancies and leave. The registered manager kept staffing numbers under review. At the time of the inspection the registered manager told us there were 13.5 full time vacancies and the service was recruiting. There was an on-call system covered by senior staff.

People were protected from abuse and harm. People surveyed indicated they felt safe from abuse and harm. There was a safeguarding policy in place. Staff had received training in safeguarding adults; they were able to describe different types of abuse and knew the procedures in place to report any suspicions or allegations. The registered manager was familiar with the process to follow if any abuse was suspected; and knew the local safeguarding protocols and how to contact the local safeguarding teams. The reporting of incidents by senior staff was good and over the last 12 months there had been a number of incidents reported. Incidents were investigated and actions were put in place to reduce further risks of occurrence. Where this related to poor performance by staff additional training and supervision had taken place. Incidents and accidents were also recorded on the computer system and sent to a health and safety consultant, where they were audited and analysed to ensure appropriate action had been taken. In addition, accident and incident details were sent monthly to senior management.

Requires Improvement

Is the service effective?

Our findings

People told us they were happy with the care and support they received. One person said, it's "nice" here. Five out of six people surveyed indicated they were happy with the care and support received.

People were not always supported to ensure they remained in good health. In some care plans there were clear records of people attending appointments. However these were not always up to date or present. An incident report showed that one person had bruising and the action was for them to visit the doctor. The registered manager told us they were aware that the person had seen the doctor, but no record could be found. It continued to be difficult to find information about when people had last seen a health professional, such as a dentist or when they were due for a routine check-up. One person had visited a consultant psychiatrist and had received a letter recommending that they had blood tests undertaken at their doctors and advising them of their next appointment in May 2016. Staff were unable to tell us if the blood test had been carried out and if the person had attended the last appointment with the consultant psychiatrist. Senior staff felt that if staff could not tell us and there was no record, then it was likely these events had not happened. Following the inspection the surgery was contacted by staff who advised the blood tests had not been undertaken. A relative surveyed commented that staff had failed to register their family member with a GP when they had moved in. The registered manager told us the person had been registered, but "It had taken longer than it should have taken". Relatives had mixed views about whether their family member was supported to receive regular check-ups and appointments. One relative told us "I have to alert them". Another person had been to see the dentist in July 2015 and a record had been made that they had been uncooperative so would need anaesthetic on a follow up appointment. Records did not show that any action had been taken, although the registered manager advised later that a follow up appointment had now been made almost 12 months later.

The provider had failed to do all that was reasonably possible to mitigate risks to people's health and safety. This is a breach of Regulation 12 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people told us staff had the right skills and knowledge to give them the support they needed. However the majority of relatives disagreed and there were shortfalls in staff training.

Staff understood their roles and responsibilities. Staff had completed an induction programme, which included reading, orientation, attending training courses and undertaking knowledge competency tests. In addition staff also undertook shadowing of experienced staff until it was felt they were competent to work alone. The induction was based on Skills for Care Care Certificate, which was introduced in April 2015. These are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life. Staff had a six month probation period to assess their skills and performance in the role.

The registered manager told us staff received initial training and this was refreshed regularly depending on the training subject. Mandatory training included health and safety, moving and handling, fire safety awareness, emergency first aid, infection control and basic food hygiene. Records showed that there were

considerable shortfalls in staff updating their training in subjects, such as epilepsy, medicines, equality and diversity, fire safety, first aid, health and safety, infection control, food safety and moving and handling. Between nine and 13 staff had not undertaken the up to date training to enable their practices and knowledge to be up to date and in order to provide safe and effective care and support to people. Some had been overdue since the beginning of 2016.

The provider had failed to ensure staff received appropriate training as was necessary to enable them to carry out their duties they were employed to do. This is a breach of Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some service specific training had been completed, including autism, dementia and mental health awareness, Prader-Willi syndrome (Prader-Willi syndrome is a rare genetic disorder that causes characteristics, such as obesity due to an excessive appetite), managing epilepsy and Buccal Midazolam administration (Buccal Midazolam is an emergency rescue prescribed medicine). Staff that worked with one person had recently received training from a health professional regarding putting in place positive behaviour support strategies to manage their behaviours. Staff told us they felt the training they received was adequate for their role and in order to meet people's needs.

The service had approximately 78 staff and 22 had achieved or were undertaking a Diploma in Health and Social Care (formerly National Vocational Qualification (NVQ)) level 2 or above. Diplomas are work based awards that are achieved through assessment and training. To achieve a Diploma, candidates must prove that they have the ability (competence) to carry out their job to the required standard.

At the previous inspection staff had not received appropriate support, supervision and appraisals. During this inspection staff told us they had opportunities to discuss their learning and development through supervision, team meetings and an annual appraisal. Most staff had recently had a supervision meeting with their manager. Records showed that team meetings were also held and two had taken place very recently. Staff had been able to discuss any issues and policies and procedures were reiterated. Staff said they felt well supported.

Most people said that they were introduced to staff; however most relatives disagreed with this. People told us they were supported by familiar and consistent staff, which would therefore be familiar with their support needs. Although relatives told us that staff "come and go" and it takes time for their family member to get to know new staff. Most people said staff arrived when they should and stayed the full time and all said staff did all the tasks they wanted them to do. The majority of relatives surveyed felt staff did not arrive on time did not stay the full time and did not do all the tasks required. There had been a very high turnover of staff during the last 12 months. A total of 55 staff had started working at the service (nine of which were bank staff) and 26 staff had left the provider's employment (seven of which were bank staff). The highest turnover had been for staff employed in the Kent area. One person's care plan stated 'changes in staff make me nervous'. The turnover figures would affect the continuity that people received over a period of time and this is an area we have identified that requires improvement.

People said consent was achieved by staff discussing and asking about the tasks they were about to undertake and made their own choices. People said staff offered them choices, such as how they wanted to spend their time. Some people were offered a choice of two items, so they could make a choice, such as breakfast cereals. However care plans were not always clear about people's capacity to make their own decisions. For example, 'I like to make my own decisions', but this did not inform staff about the person's capacity to make different sorts of decisions. One care plan stated that the person was 'deemed as uncapable of managing their medication independently'. However there was no record of the capacity

assessment that led staff to that judgement. This is an area we have identified as requiring improvement.

The majority of staff had received up to date training in Mental Capacity Act (MCA) 2005. The registered manager told us that three people were subject to an order of the Court of Protection. The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The registered manager told us they had been involved in a best interest meeting about an area of the future arrangements of a person's care and support. The decision making had involved the person, their care manager, the community learning disability team, family and staff. They demonstrated they understood the process to be followed.

Care plans contained information about how a person communicated and what support was required to enable good communication, such as 'make sure I have understood what you have said by repeating it back to me if I seem unclear. Keep conversation simple do not overload me with information. Give me time and don't try to guess what I am trying to say I will find the words I need be patient as I like a chat'.

People's needs in relation to support with eating and drinking had been assessed during the initial assessment and recorded. Most people required minimal support with their meals and drinks if any. People were supported to plan and shop for their meals. Staff then prepared a meal from what people had in their home. Some people had chosen to lose weight and this was supported by staff. Care plans showed that some people had adapted cutlery, plate guards and non-slip mats to aid their independence. Where there were risks relating to nutrition, measures were in place to reduce these risks. For example, foods were cut into small pieces when there was a risk of a person choking.

Requires Improvement

Is the service caring?

Our findings

People told us staff listened to them and acted on what they said. Most people said staff were kind and caring. Comments included, "It has the right feeling here". "I am really enjoying it". "The carers here are really good, I can talk to all of them, there's no one I don't get on with". "The staff are brilliant and helpful". "The atmosphere is good here; you can have a laugh and a joke, staff and people together there's no divide".

Relatives told us that some staff were more committed than others and the changes were unsettling. Other comments included, "(Support worker) has been there a long time and she's very good". "(Support worker) takes the initiative, not all do".

During the inspection the staff took the time to listen and answer people's questions. People were relaxed in the company of staff. Staff had received training in treating people with dignity and respect as part of their induction. People told us that they were treated with dignity and respect and had their privacy respected. However the majority of relatives surveyed disagreed.

One relative told us via the survey that when they had visited they had seen a person from the next door flat having treatment from a health professional in the lounge of their family member's flat. This situation did not enhance people's privacy or dignity.

A relative had commented on a survey that one person's lounge had been used for moving and handling training and during this time was not available to be used by the person. Records showed that the person had also complained to senior staff about this. Senior staff had responded and felt this was acceptable as the training was specific to one individual that lived there. However at no point did the response say that the person or others who lived in the flat had been asked permission to use their lounge, which would have shown the required respect from staff and consideration of people's privacy in their own home.

Another relative talked about their family member being partially sighted and staff not being respectful of this. They gave examples of putting their meal in front of them without placing their hand on the plate so they knew where it was and leaving the room and going out into the garden without telling the person they were supporting. They talked about sometimes when they arrived and their family member was slouched in the chair and they had to ask for help to make them comfortable.

The provider had failed to ensure people were treated with dignity and respect and ensure people's privacy. This is a breach of Regulation 10 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff used different forms of communication to ensure people were able to make their needs known. For example, staff used pictures and photographs to plan one person's day with them. Staff told us they also used symbols and Makaton to communicate effectively with people. Makaton is the use of signs and symbols to support speech. Staff involved people in discussions about what they wanted to do and where they wanted to go, and gave people time to think and make decisions.

People told us they received person centred care that was individual to them. People felt staff understood their specific needs relating to their age and physical disabilities. Staff demonstrated through discussions they had built up relationships with people and were familiar with their life histories and preferences. Care plans contained some details of people's preferences, such as their preferred name. The registered manager told us that further work was required to ensure information about people's past lives were recorded in their care plans. During the inspection staff talked about people in a caring and meaningful way. We observed interactions between people and staff, which were kind and patient and often used good humour.

Most people told us the support and care they received helped them to be as independent as they could be. However seven of the eight relatives surveyed indicated that the care and support their family member received did not help them to be as independent as they could be. Staff felt they encouraged independence and talked about people washing up and putting away dishes and clothes. However this was not always supported by care planning. Daily notes made by staff showed that people were involved in household tasks. One person told us, "I am getting a lot of my independence back, which had made a big difference to me" and "I do like that about here staff stand back, but are there if you need them". One social care professional felt that some staff were excellent at enabling others, but others were not. Relatives told us they felt more could be done to aid independence.

People told us they were involved in the initial assessments of their care and support needs and planning their care. Some people had also involved their relatives. People felt care plans reflected the care and support they received. The registered manager told us at the time of the inspection most people did not require support to help them with decisions about their care and support, but if they chose were supported by their families or their care manager, and no one had needed to access any advocacy services. Details about how to contact an advocate were available within the service. Information given to people confirmed that information about them would be treated confidentially.

Requires Improvement

Is the service responsive?

Our findings

People were involved in the initial assessment of their care and support needs and then planning their initial care and support. Some relatives had also been involved in these discussions. The registered manager was part of the team of people that undertook the initial assessments. Additional information from health and social care professionals involved in people's care and support had been obtained, to make sure they had the most up to date information about the person. In one case records showed that the care plan from the previous placement had also been obtained for information.

At the previous inspection the level of detail within care plans varied greatly and in most cases required further information to ensure that people received care and support consistently, according to their wishes and to show that staff promoted people's independence. We found that although care plans had been reviewed there continued to be shortfalls in some care plans to ensure people received consistent support according to their wishes.

One care plan showed good detail about what the person could do for themselves during washing, but lacked detail about what the person could do for themselves when drying and dressing, to ensure their independence was maintained or encouraged. Within the care plan the equipment required during personal care was identified, but this lacked detail about where the person would get dressed and dried, on the shower/commode chair or on the side of the bed. The care plan stated 'I can do somethings with staff support'. It also talked about the person having a pet and needing support with this, but again it did not specify what support was required, to ensure the person did as much as they could themselves. The care plan talked about a behaviour protocol, but senior staff told us there was not one and the information was incorporated into the care plan and risk assessments, which could be confusing for staff that were supporting the person.

Another care plan stated that 'other forms of communication are sounds and facial expressions', but there was no detail about what these were or what they would mean. The care plan was confusing between what the person was aiming to achieve and what care and support they required at the time of the inspection. For example, they were aiming not to use continence products, but it was confusing when they were at home whether they did or did not and relied on staff to prompt them to use the toilet. Within the personal care section the care plan stated 'I need full support with my personal care', but this did not specify what their preferences were in relation to this. For example, did they prefer their bath in the morning or evening? The care plan also stated that the person wanted to learn to use the washing machine and do other household tasks, saying 'it is important that I am involved in all aspects of my care to increase my independence and meet my wishes'. However there was no detail about what skills and abilities the person had at this point in order that they could be maintained and developed.

One care plan stated 'lock kitchen if staff not present in flat'. However senior staff told us this restriction was no longer in place, but the care plan had not been updated, to ensure staff were clear about how the person should be supported.

We looked at the care plan folder in one person's home and found this only contained care plans, which were out of date. For example, they stated that a door alarm was in place to monitor the person's movements, but staff told us this was no longer the case. The care plan also stated that 'staff should check on my whereabouts at all time during the night', but this person had a member of staff sleeping on the premises and not a wake night. The registered manager told us that senior staff had taken the care plan to update it as they had made handwritten adjustments on the advice and guidance of a health professional. However at the time of the inspection there was no current information available for staff as this was still to be typed up and a copy was not available.

The registered manager told us care plans were developed from discussions with people, observations and assessments. One person told us they were aware of their care plan and people who had completed surveys indicated they were involved in decision making about their care and support. However the care plans did not contain any evidence that people had been involved in care plan discussions or agreed with the content of their care plan.

At the previous inspection we found that review meetings between people, staff, families and care managers had been held, but there were not always notes of these meetings, particularly when the minutes had not been received from the authority funding the person's care and support. This continued to be the case in some instances and we were reliant on staff remembering whether a review meeting had taken place or not. The information about what had been discussed and agreed at the review meeting regarding the future care and support of the individual was not available for staff and may leave a risk that action agreed may not have been implemented and this continued to be the case.

The provider had failed to ensure that information within the care plan reflected people's assessed needs and preferences. The above is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People did not have opportunities to provide feedback about the service provided. All relatives surveyed indicated that had not been asked about the service their family member received. The last quality assurance surveys sent out to people, relatives and professionals had been in December 2014. This had been organised centrally at head office and no surveys had been sent out since. People should have had review meetings with staff, their family and care manager and this would have been an opportunity for them to ask about the service they received and gather feedback. However notes/records of any meetings that had taken place were not available.

The provider had failed to seek and act on feedback from people and others involved with the service for the purpose of continually evaluating and improving services. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People told us they felt confident in complaining. Most people who had completed our surveys indicated they knew how to complain and said staff responded well to any complaints or concerns they had raised. However two people did not feel senior staff responded so well to issues raised and the majority of relatives indicated that staff did not respond well to complaints or concerns raised. Some of the concerns we received from relatives related to the property where their family member lived. However as this is a domiciliary care agency we do inspect people's property, but we did discuss their comments with the registered manager. One relative complained that a person's lounge had been used for staff training and we saw from records that the person had also complained about this and received a response. There were various easy read complaints procedures displayed and available to people and complaint records showed that complaints had been responded to in a timely way.

People were not socially isolated. Some people were supported to be ready to attend groups and daycentres within the community. Others were supported to access the community and undertake activities they enjoyed. One social care professional felt that they had seen an improvement in the support of the person they represented who was now being supported to access the community whereas before they were not. One relative felt more could be done to provide a wider variety of activity opportunities for their family member. Although another relative told us that recently their family member had been supported to attend an activity which they had been trying to access for a long time.

Requires Improvement

Is the service well-led?

Our findings

Most people we surveyed indicated that they would recommend this service to another person. However all eight relatives surveyed indicated they were not happy with the service their family member received and would not recommend this service to a member of their own family. Most people felt they knew who to contact at the service if they needed to and most relatives indicated they did not. One relative told us, "This is the right place for (family member), but the service could be better".

The registered manager was supported by three service managers who had responsibility for three areas within the location and two of these had left recently. Two new managers had very recently been appointed and at the time of the inspection were still getting to grips with their role, getting to know the people they were responsible for and the staff they managed. The service managers were supported by five and half full time team leaders, although one post was vacant. In addition there was a team leader responsible for another area. The service managers were responsible for people's care plan and review meetings, organising their support, staff supervision and monitoring their training. One person said of the new senior staff, 'so far so good'.

During the last 12 months the changes in staff within the service and a lack of proper systems and process in place to effectively manage the service had impacted on services people received. Two senior staff who managed two of the areas day to day had left. This followed a period where the registered manager had been closely monitoring staff after identifying concerns. One person surveyed had commented, "I feel that without a manager here things run better and everyone is happier. I feel that my opinion doesn't count anymore and we are looking to move due to the lack of consistency here. Things that were promised before I moved in have never happened and now I'm being told the opposite. If I knew these things before I would never have moved here". A relative told us there has been quite a lot of staff changes in the past year they were due to attend their family member's review with staff and social services at the beginning of last year (2015). It was cancelled and they heard no more of another date. So this January they asked for a review to get their issues attended to. The review was due to take place the following week, but at the time of writing the survey they had had no contact from staff. They were concerned as the person was not able to express their needs very well. One relative commented that the standard or quality of the service provided was not what they were led to believe prior to the family member moving in. They felt they had received resistance from management when suggestions were made to improve situations, very slow response times on behalf of management procedures and difficulties in getting management to act on decisions made. Another relative told us they had to "push hard" for things to be done and then they took a long time. One relative told us the management were not "very efficient, they don't react efficiently in some cases and situations". One social care professional told us as far as leadership was concerned it was difficult to comment as the service had such a high management turnover. They were hoping that the new service manager would stay and commented that the team leader was excellent.

We visited the Norwood office on the second day of the inspection and found in the registered manager's words this to be "chaotic". The service manager was off on leave and the registered manager told us that cover had been arranged. However when we arrived no senior staff had arrived for duty, although they did

arrive later. Shortly after we arrived a care manager arrived with a person who was moving in that day, although no staff were on site to support this. The registered manager checked the staff rota displayed and could find no detail of the support arrangements for the person moving in that day. After a period of time spent talking to the person and their care manager a support worker arrived who was allocated to support the person, although they did not come into the office and introduce themselves to the person, they did introduce themselves soon afterwards. After considerable time the person was shown to their flat by staff. Sometime after the inspection the registered manager told us that the person moving in had arrived two and a half hours earlier than expected and some items of furniture had not been delivered when they arrived at the service, which was why the service seemed unprepared.

There was a lack of effective communication within the service. One staff member told us "Communication hasn't been its best". Another staff member told us they felt the communication with the office could be better. They talked about how they had informed senior staff of a person's hospital appointment, which would mean they would need the one to one support to come in early on that day to ensure the person was ready for their transport, but staff had not been arranged properly so they had to manage on their own, which would have put their health and safety at risk. Staff also told us they did not know what they were working the following week because the rota was completed at short notice, which in turn meant people would not know who would be visiting them either. One relative told us "Communication and contact is poor". Another relative commented that there staff shortages as they were under the wrong impression that two staff would be on duty in the flat where their family member lived. Records showed that the hours contracted for the people living within that flat would not result in two people being on duty at all times. One person and relatives felt that how the service was portrayed during the assessment process did not reflect the service they or their family member received. One staff member said of a previous service manager who had recently left, "(Service manager) not the best communication skills, they were very black and white and they could have handled things better".

Records also showed that in one area sickness levels were very high during January to March 2016 with weekly sickness hours recorded as high as 183 hrs per week. Some staff told us that under previous senior staff they had not always received regular supervision, that they had not been friendly and had not always listened easily dismissing staff's ideas. An example was discussed with the inspector. We discussed this with the registered manager who told us that staff had approached them with their concerns and they had taken action where they were aware of problems.

Details of the contracted support hours for people were recorded in their care plans. However these did not always match the hours delivered. The registered manager had a list of what hours people were allocated and rotas confirmed that people were not all receiving the hours allocated. For example, one person was getting 98 hours per week and records showed was only contracted for 94.5 hours. Another person was only getting 98 per week, but records stated they were contracted for 105 per week. This meant people could not be confident they were receiving the right amount of support hours.

People and staff did not have proper opportunities to provide feedback about the service provided. The registered manager told us that no quality assurance surveys had been sent out to people, their relatives or professionals involved with the service since December 2014. This had previously been undertaken by head office, but had been cascaded to happen locally. However due to poor communication the registered manager told us they had not understood this and surveys had not been sent out. Staff had received a survey, but this was in relation to the organisations values and not asking for feedback on services provided.

Audits were not effective in ensuring procedures were followed to mitigate risks to people. One person and relatives that was surveyed indicated that support workers did not do all they could to prevent and control

infection (for example, by using hand gels, gloves and aprons). Discussions with staff identified that in one area people were purchasing their own gloves and these were not supplied by the provider. This was brought to the attention of the registered manager who immediately informed senior staff that personal protective equipment should be purchased by the provider.

Management systems were not effective in ensuring people received a quality service. A training report was sent to the registered manager from head office each week and this was then cascaded to senior staff. Senior staff should then have ensured that staff's training was up to date and they undertook refresher training within the set timescales, but this was not effectively managed as considerable refresher training was not happening in a timely way. There was no effective system in place to identify, which staff had received supervision and appraisal and when and what had been booked. There was also no effective system to ensure people received their annual review meeting.

Monthly data was sent to the senior management team. The report was based on a traffic light system. We saw that the report for May 2016 showed that training was rated red, amber and green, percentage of agency hours used was rated as red, amber and green, vacancies was rated as red and amber and incidents were rated as amber and green. These reports were then discussed at meetings the registered manager attended monthly.

The compliance and regulation team had undertaken an audit of the service based on the current inspection methodology of the Commission in January 2016 and this was a follow up on a visit undertaken in February 2015. This had included a visit to the office and visits to people using the service. This had all been collated into a report of the findings. The report had identified that improvements were slow in the areas where the service managers had changed, but this had not ensured action by taken to ensure compliance.

The provider had failed to establish and operate effectively systems and processes to ensure compliance with the requirements. The above is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People, relatives and staff had confidence in the new service managers to make the improvement that were required. One person said of one of the new service managers, they are "very approachable and speak to you at your level. They respect this is our home. (Service manager's) a nice guy". They had confidence this new manager would resolve any of their concerns. A staff member said of the same manager, "Now it is starting to be better, I have seen a difference since (service manager) started we are on the right route. They are getting on well, have good people skills, the staff team seemed to have relaxed and feel they can approach them". A relative told us "The manager always comes down to see me; they are focussed on the people". Another told us, "We are getting to know them (service manager), there have been a lot, but this one seems to be doing and is more proactive".

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure people were treated with dignity and respect and ensure people's privacy. Regulation 10(1)(2(a)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to do all that was reasonably possible to mitigate risks to people's health and safety. Regulation 12(2)(b)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff received appropriate training as was necessary to enable them to carry out their duties they were employed to do. Regulation 18(2)(a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that information within the care plan reflected people's assessed needs and preferences. Regulation 9(3)(b)

The enforcement action we took:

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Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish and operate effectively systems and processes to ensure compliance with the requirements. The provider had failed to seek and act on feedback from people and others involved with the service for the purpose of continually evaluating and improving services. Regulation (2)(1)(2)(b)(e)

The enforcement action we took:

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