A Plus Care Ltd

# A Plus Care Ltd

## Inspection report

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29 January 2019
01 February 2019
12 February 2019
14 February 2019

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

About the service:

A Plus Care Ltd is a domiciliary care provider in the East Sussex town of Bexhill, which is situated close to the coast. On the first and second day of inspection, 38 older people received personal care support from the service. On days three and four of the inspection, 27 older people were receiving personal care. Some of these people were living with dementia.

Not everyone using A Plus Care Ltd received the regulated activity 'Personal care' that CQC inspects, which includes support with personal hygiene, eating and drinking. Where they do we also take into account any wider social care provided.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

People's experience of using this service:

Before the inspection, the provider had limited involvement with the service and had allowed the registered manager to manage it independently. Therefore, when the registered manager left the service earlier than expected, the provider was not familiar with people, their needs, the regulations or their responsibilities. We found two incidents were not reported to the local authority or CQC within relevant timeframes. The provider required guidance in how to complete these referrals. Some areas for improvement identified at the previous inspection had not been actioned. There was a lack of oversight for concerns that had been raised previously with the registered manager. Supervisions, spot checks and team meetings had not been completed consistently. Although the registered manager acknowledged this was an area for improvement, they had not notified the provider. The current CQC rating was not displayed on the website as per regulation.

It was identified at the previous inspection that people without capacity to make decisions, did not have mental capacity assessments. We recommended that research was completed into responsibilities under the mental capacity act. The registered manager had undergone training in this area to develop their knowledge. However, they advised us they were still unclear of their responsibilities. They had not sought any further guidance on this.

Although people told us they felt safe, one person had not received their medicines consistently. Actions were not taken in a timely way by the provider or interim manager to ensure their wellbeing and notify relevant others.

People had assessments that detailed risks to their health and wellbeing and actions staff should take to reduce this. Staff knew people well and how to manage these risks. There were contingency plans for staff shortages or emergency situations that highlighted those people who would need priority support. Staff had

a good understanding of potential signs of abuse and of who they would need to report any concerns to.

Despite frequent changes to staff and people's care packages, the company administrator was managing the rotas well. People still received support from familiar staff. There had been no missed or late care calls since the registered manager had left. The provider and company administrator were speaking to people and staff to understand their care needs and ensure these were being met. The provider also advised they would not be taking on any other care packages until a robust management structure had been implemented.

People and their relatives told us that people's health and nutritional needs were met. If they required support from staff with appointments, this was given. People had involvement from health and social care professionals frequently to improve their wellbeing. Where staff had identified concerns with the person's environment, the registered manager had made referrals to professionals to gain equipment that would support them. Staff told us that training was good and gave them the skills they needed to meet people's needs.

People and their relatives were consistent in their responses that staff were kind, caring and attentive to their needs. Many people considered staff to be extended family. They told us their independence, privacy and dignity was respected and promoted at all times. Staff had a good understanding of equality and diversity and supported people in their diverse beliefs and choices.

People and their relatives told us that the registered manager and staff were responsive to them and any changing needs. Pre-assessments completed before the person received support were then used to create a care plan about the person, their needs and preferences. People and their relatives told us any concerns they had were dealt with immediately by the registered manager. Staff had a good understanding of people's communication needs.

Although staff had initially been concerned about the registered manager leaving, they told us that the provider, business director and company administrator had worked hard to ensure that changes did not impact on people. Staff had been able to talk to the provider directly with any concerns or worries about the future and been reassured. The provider advised that this inspection had identified their need for clear oversight of the service. They had already considered how this could be improved to prevent a similar situation occurring again. They had also arranged for support by the local authority to improve their knowledge of roles and responsibilities.

Rating at last inspection:

At their previous inspection, A Plus Care Ltd were rated Requires Improvement. (Report published 15 March 2018) At this inspection we found not all concerns raised at the previous inspection had been addressed. The registered manager left halfway through the inspection and the provider did not have clear oversight to manage the service. This is therefore the second time that A Plus Care Ltd have been rated Requires Improvement overall.

Why we inspected:

We brought this inspection forward following information that the registered manager was planning to leave. We required reassurances that the service would be managed effectively in their absence by the provider.

By day three of the inspection process, the registered manager, care co-ordinator and three other staff had left the service. We received four staff and two relative's concerns. Therefore, we completed a further two inspection days to ensure people were safe.

Enforcement:

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009.

We have served a warning notice for Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider must be compliant by June 2019. We will check the warning notice has been complied with at our next inspection.

Follow up:

We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

| | |
|---|---|
| **Is the service safe?**<br>The service was not always safe.<br>Details are in our Safe findings below. | **Requires Improvement** |
| **Is the service effective?**<br>The service was not always effective.<br>Details are in our Effective findings below. | **Requires Improvement** |
| **Is the service caring?**<br>The service was caring.<br>Details are in our Caring findings below. | **Good** |
| **Is the service responsive?**<br>The service was responsive.<br>Details are in our Responsive findings below. | **Good** |
| **Is the service well-led?**<br>The service was not always well-led.<br>Details are in our Well-Led findings below. | **Requires Improvement** |

# A Plus Care Ltd

**Detailed findings**

## Background to this inspection

The inspection:

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We brought this inspection forward following information that the registered manager was planning to leave. We required reassurances that the service would be managed effectively in their absence by the provider.

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Inspection team:

Inspection site visit started on 29 January 2019 and ended on 14 February 2019.

Days one and two of the inspection were completed by one inspector. Days three and four were completed by two inspectors. Although not present at the office, two experts by experience supported the inspection process by talking to people and their relatives over the telephone. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. By day three of the inspection, the registered manager had left the service. An interim manager had been introduced to manage the service in their absence.

Notice of inspection:

We gave the service 48 hours' notice of the inspection visit because it is small and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in. We also needed to seek consent from people and their relatives to receive phone calls.

What we did:

During the inspection we reviewed;

- Information we had received about the service. This included details about incidents the provider must notify us about
- We used information the provider sent us in the Provider Information Return [PIR]. 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
- Completed CQC surveys from people who used the service
- Rotas and contingency plans
- Seven people's care records
- Four people's medicines records
- Seven staff files, including recruitment, training and supervision records
- Records of accidents, incidents and complaints
- Audits and quality assurance reports

We spoke with;

- Six people using the service
- Nine relatives
- Nine members of care staff
- The provider, business manager, company administrator, registered manager and interim manager
- The local authority

Requires Improvement

# Is the service safe?

## Our findings

Safe – this means people were protected from abuse and avoidable harm

Requires Improvement: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

At their previous inspection, A Plus Care Ltd were rated Requires Improvement in Safe. This was because people did not always have all their risks assessed, particularly regarding specific health conditions. People that received 'as required' medicines did not have guidance informing staff how and why this should be given. At this inspection, we found that significant improvements had been made to these areas. However, further concerns were identified regarding taking action in timely way and reporting incidents. This is therefore the second time that A Plus Care Ltd have been rated as Requires Improvement in this domain.

Using medicines safely

● One person had not consistently received their medicines. Actions had not been taken in a timely way to check on the person's wellbeing or to prevent the incident happening again. The provider had not informed other relevant authorities. The referral to the local authority happened during the inspection, only because we asked the provider to. When we discussed this with the provider they acknowledged that actions should have been taken sooner but, they had learned from this incident.
● The person's medicine administration record (MAR) for the previous month, showed other gaps in recording that had not been identified by the registered manager in the medicines audit.
● Other areas of medicines were safe. People told us they received their medicines safely. One said, "They make sure I have everything I need in the morning so I can take them myself."
● One person had time specific medicine for a health condition. Care calls were fixed to ensure medicine was given at the correct times and these were highlighted on their MAR charts.
● Where people were prescribed medicines on an 'as required' basis, there were clear records to indicate why the person would need the medicine and how often it was to be given.
● Staff had completed training in the safe administration of medicines and had their competency assessed by the registered manager.
● When the registered manager left, the interim manager was auditing people's medicines and ensuring they had MAR's in their homes.

Assessing risk, safety monitoring and management

● People had assessments that identified areas of risk and how this could be reduced. This included risks associated with their environment, moving and handling, falls, skin integrity and continence management.
● Staff supported the same people on a regular basis and were aware of risks to their health or social wellbeing.

● Some people had specific health conditions and there were clear assessments identifying how this impacted on the person and signs to look for when they were unwell.
● For one person with anxiety, there were robust moving and handling assessments. These included alternative guidance for if they were not feeling well.
● One relative told us that staff were good at identifying risks for their relative, who had a sight impairment. They said, "One example is when a carer has pre-set the time on the microwave to provide her with meals of the right temperature, so all my mother has to do is put the food in the oven and close the door."
● There was a business continuity plan for in the event of an emergency. This included steps to take in severe weather conditions. The registered manager had devised a priority care calls document which risk assessed people's needs. People who presented as a higher risk, for example those who lived alone or in an isolated area, would be prioritised in an emergency.

Learning lessons when things go wrong

● Incident and accident reports detailed information of the incident, immediate and on-going actions taken and reflected on lessons learned.
● There were several incidents regarding a person displaying behaviour's that challenged. The registered manager supported staff with their understanding by sourcing additional challenging behaviour training.
● The registered manager said, "It's horrible when things happen but you do learn from them. I've learned to ask more questions in the initial assessment process."

Staffing and recruitment

● People and their relatives told us that recently, some of their care calls had been late. Two people had missed care calls. In all situations, people and their relatives told us this had not impacted on people's well-being and that the registered manager had responded instantly. The registered manager knew about these concerns and had a plan to improve this with staff.
● By the third day of inspection, the registered manager had left and we were advised that several other staff had resigned with immediate effect. 11 people had also chosen to cancel their packages of care. Some of these had done so to continue receiving support from staff that had left. We received several concerns from staff that the provider would not be able to manage rotas, as they did not know people or the staff that regularly supported them.
● We saw that despite regular changes to staffing and care packages, they were managing this well. People were receiving calls at the right time and from staff that they knew well. Since the registered manager had left, there had been no late or missed care calls.
● The provider, business director and company administrator were in the process of reviewing people's care plans and talking with staff to better understand people's needs.
● Staff told us that they were still providing support to the same people and had time to get to each care call without feeling rushed. One staff member said, "The provider and company administrator are doing the best they can. They respond instantly as well if we need answers." Another said, "Rotas have been slightly different but not bad at all. Everyone is getting care calls, which is the most important thing."
● The provider told us that they would not be taking on any new packages of care until a new registered manager had been found and concerns resolved.
● The provider had completed background checks on new staff as part of the recruitment process. This included applications to the Disclosure and Barring Service, which checked for any convictions, cautions or warnings.
● References from previous employers were also sought regarding their work conduct and character and these were evidenced in staff files.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe. One person said, "Most make me feel that they are really looking after me. They walk with me to make sure I am alright." Another said, "I feel very safe, carers ask lots of questions about my health and are constantly keeping a check on me."
● Relatives felt confident their loved ones were kept safe. Comments included, "I feel very safe leaving my relative in the hands of A Plus Care Ltd, as they have a good track record" and, "In a word, I am very impressed." One relative said, "Staff have got the care plan in action, so I know carers are going to be there four times a day and that gives me the confidence of her being looked after when I'm out of the house as a relative."
● Staff were aware of signs of potential abuse and who to report to with any concerns.
● Staff had all received safeguarding training that was regularly reviewed.

Preventing and controlling infection

● People told us that staff always wore gloves and aprons when supporting with personal care or when preparing food.
● Staff had all received infection control training and had a good understanding of how to prevent the spread of infection.

Requires Improvement

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

RI: The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

At their previous inspection, A Plus Care Ltd were rated Requires Improvement in Effective. This was because assessments had not been completed for people that were unable to make decisions themselves. Staff had also not received training to support people with specific health conditions. During this inspection, we found staff had received training to meet all of people's needs. However, assessments related to mental capacity had still not been addressed. This is therefore, the second time that A Plus Care Ltd have been Requires Improvement in this key question.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; ensuring consent to care and treatment in line with law and guidance

- 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.
- For those people who lacked capacity, they did not have individual capacity assessments that explored the decision-making process.
- There was limited evidence to demonstrate that the person's views and those involved in their care such as relatives or social workers had been taken into consideration.
- One person had part of a mental capacity assessment completed. This included a conversation held with the person but did not contain a conclusion, best interest decision or input from others. The registered manager advised they had started this, but was unsure how to complete it.
- The registered manager advised that they had attended an advanced training course with the local authority but had still not fully understood their requirements to meet the MCA. They had not sought any additional support to develop their understanding. Therefore, no further improvements had been made to MCA concerns raised at the previous inspection.

The provider had not ensured that all care and treatment was provided with consent from the relevant person. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us that they were offered choice at all times when supported by staff. One person said, "I am in control of my care", while another said, "Staff always ask me first."
- Staff had a good understanding of the mental capacity act and how it applied to people they supported.

They gave examples of how they would support someone without capacity to make decisions, such as using pictures or objects of reference.

Staff skills, knowledge and experience

● People told us staff had the skills and knowledge to support them. One said, "I feel staff have a good underpinning knowledge to deal with my needs." Another said, "I had a health problem recently and the carers were very effective in knowing exactly what to do in the situation."
● Relatives also felt staff were well trained. One told us, "I believe the staff at A-Plus Care Ltd have the right amount of training to look after everything my relative requires."
● Staff told us they had received more specialised training in dementia, diabetes and epilepsy and this had given them the skills they needed to meet people's specific needs. Staff also told us they had received training in managing behaviours, following a series of incidents of behaviour that challenged with one person. One staff member said, "It was really useful as it taught me how to support the person if they got anxious or agitated."
● Staff told us they received a full induction, that included learning about the care role, training and shadowing more experienced staff. One staff member said, "When I shadowed one staff member I loved how people really loved them and they had built such good relationships with them. I strive to be like that."
● New staff also completed the care certificate as part of their induction. The Care Certificate is a nationally agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.
● Following induction, staff were supported in their roles with supervision. Although staff acknowledged that they hadn't received as many supervisions recently, they felt they had enough support. One staff member said, "I can always ask for extra supervision if I want it. Office is always open so can say straight away if any worries." Another said, "I feel like I get enough. I also ask for supervisions if I need it. I can talk about anything and everything."

Supporting people to eat and drink enough to maintain a balanced diet

● People that had support with preparing food and drink, told us staff always made sure they had enough and they could choose what they wanted. One person said, "They make my breakfast and do what I want – it is always well cooked."
● One person required encouragement to drink and for their fluids to be monitored. We viewed fluid charts and guidance and staff were aware of the person's support needs in this area.
● Staff had all received training in promoting good nutrition and hydration, which was regularly reviewed.

Adapting service, design, decoration to meet people's needs

● Staff told us about one person they had been concerned about, who was at risk when using the shower. An occupational therapy referral was made immediately and additional equipment fitted to support the person to move safely.
● A relative told us how staff had made recommendations to move furniture in a person's home to reduce risk and enable them to move around more easily. "Their suggestions were so useful and help my mother to be more safe and independent."

Supporting people to live healthier lives, access healthcare services and support; Staff providing consistent, effective, timely care within and across organisations

● People told us, "If I am unwell, I tell staff and they support me to make an appointment with my GP" and "I think they would come with me to appointments if I needed them to."
● Relative's told us that people's wellbeing was, "Staffs main concern" and "They always talk to me or make suggestions if anything arises." One relative said, "If there is a problem with my mother's health and I wasn't present, the support staff have been very good in reporting back to me in a timely manner before contacting a GP."
● We saw that people had received regular input from health and social care professionals to improve people's well-being. This included GP's, specialist nurses, physiotherapists, occupational therapists, the mental health and dementia support teams.

Good

# Is the service caring?

## Our findings

Caring – this means that the service involved people and treated them with compassion, kindness, dignity and respect

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity

● People were consistent in their views that staff were, "Kind", "Very caring" and "Go out of their way to do things for me." One person said, "Staff know exactly how I like things done – for example they know I like hot cross buns, they know I like my tea very hot." Another said, "I have a good relationship and great familiarisation with the same carers and they almost became my friends like an extended family."
● Relatives agreed about the caring nature of staff. One told us, "I think staff have been absolutely suburb. They have been professional and yet caring they have been responsive and attentive, they have respect for my mother." Another said, "I think the carers are a lovely bunch of people who care for my relative a great deal."
● One person was receiving respite at another service for several weeks. Two staff members had gone to visit them to see how they were. One staff member said, "I wanted to make sure they were okay and to reassure them we would be there when they came home."
● Staff had a good understanding of equality and diversity and had all received training in this area. One staff member said, "We work with people, not objects. People are not the same, they are all different and have different needs and wishes. We can't treat them all as the same person but we can treat them all with dignity and respect." Another told us, "Each individual has their own rights and thought and beliefs - you may not agree with it but you need to respect it."
● For one person it was important to them to go to church every Sunday. Their care call times were amended so that they could be supported by staff in time to attend.
● For two other people it was important to them that they did not have male carers. This choice had been respected and met by the registered manager when allocating staff to their care calls.

Supporting people to express their views and be involved in making decisions about their care

● People told us they had regular reviews of their care with the registered manager or care co-ordinator. This involved going through their care plans and discussing any areas for improvement.
● Where people were not always able to share their views, relatives were invited to express their opinions.
● One person said, "Sometimes management visit me to go through my care plan. Other times I just get a phone call to check I am happy with everything."

Respecting and promoting people's privacy, dignity and independence

● People told us they felt respected at all times by their carer's. One said, "They respect my privacy and dignity, honestly they couldn't be better. If I was to tick boxes, I would give them all ten out of ten."

● One relative told us, "The carers are incredibly respectful to my mother's care and realise even though she's blind she is determined to be as independent as possible." Another said, "They do try and get my relative to do as much as she can."

● Staff gave us examples of how they would promote a person's dignity and privacy when supporting with personal care. This included, asking people how they would like to be supported and talking them through what was happening. One staff member said, "People can feel vulnerable when being supported to have a shower, therefore it is important to create a safe, private space. Covering up with towels to protect their dignity is vital."

● Staff understood the importance of sharing information on a "Need to know" basis. They advised if they needed to talk about people's care, this would be done with the registered manager in the office. People had two care plans, one in their homes and one in the office. People chose where they wanted to keep their care plans at home and office copies were locked away in a filing cabinet.

● Staff had a good understanding of promoting independence. One said, "I encourage them – I don't do for them. I understand they feel good when they do things themselves."

● One person was receiving support following an operation and required support to move around their home. The registered manager sought advice from a physiotherapist and occupational therapist to provide guidance to staff and to adapt the home environment. Staff told us they provided lots of encouragement and praise, with step by step guidance for the person. As a result, the person now longer needed home care support. The service had received a thank you card from the person, which said, "This is an excellent service, I am very grateful. You have supported me to be independent. I thank you all from the bottom of my heart."

Good

# Is the service responsive?

## Our findings

Responsive – this means that the service met people's needs

Good: People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● From August 2016, all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard (AIS). The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively.
● We received feedback from one person and three relatives that not all carers were confident in speaking English and although they were, "Very friendly and caring", this affected communication at times. We spoke with five staff whose first language was not English and found communication to be clear and understood. The provider was aware that this had previously been raised as a concern and had taken actions to address it. Before staff began supporting people in their homes, the provider asked them to complete an English and numeracy test. This identified if there were any concerns with communication. One staff member told us that they lacked confidence sometimes in this area, but that the provider had sourced an English teacher to provide lessons to improve this. In the mean-time, they were going out on double up calls with other staff, to ensure good communication with people.
● Staff had a good understanding of how to promote communication with people they supported. They gave examples of supporting people who were non-verbal to make decisions. This included showing them several items and asking them to point at what they wanted.
● One person had a health condition which affected their speech. A staff member that supported them regularly told us, "It's about being patient and giving them time to answer. I would never finish a sentence for them."
● People's care plans had detailed communication assessments that identified their preferred method of communication. If they were non-verbal, there was information about alternative ways that they communicated, such as facial expression or sounds.
● Pre-admissions assessments were completed with each person before they received support in their homes, which identified their support needs, preferences and wishes.
● These pre-assessments were used to formulate the person's overall care plan. This included detailed information on what support was needed on each care call, the person's preferences and where things could be found in their home.
● People and their relatives told us they were involved in regular reviews of their care. We saw evidence that this happened regularly and that where people had capacity to make decisions, their views were sought and respected.
● Staff told us that some people had social activities as part of their care packages and that they organised these based on people's interests and preferences.
● One person liked flowers and had been supported to go to a garden centre. Another person went out for regular walks or to a local coffee shop. They had also been supported to go to Eastbourne Harbour for a

meal.
● The registered manager told us they had been trying to involve people and the community in activities. They had held two coffee mornings at the office to raise money for charity. One of these had been particularly successful, in that they had raised £270 for Macmillan. The registered manager said, "These events were great in that people got to meet each other. Members of the community also joined us and that raised awareness of the service."

Improving care quality in response to complaints or concerns

● At the time of inspection, no formal complaints had been received from people or their relatives.
● People told us that if they had any concerns, the registered manager responded instantly. One person said, "I think responsiveness to our need to vary the care provided has been the most impressive thing the service has done for us and the ability to adapt to any changes have been over and above." Another person said, "They sent a new carer and I did not like them so I complained to the manager and they have not been sent again. The manager always reacts straight away."
● Relative's agreed that any minor concerns had been addressed immediately. One relative said, "I can ring the manager straight away, I can also just walk into the shop. The manager is open to communication."
● On the third and fourth day of inspection, the registered manager was no longer at the service. The interim manager and provider had phoned people and their relatives. They had also drafted a letter to reassure them and advise who they could speak to with any concerns in the registered manager's absence.

End of life care and support

● No-one was receiving support with end of life care at the time of inspection.
● For people that had Do Not Attempt Resuscitation (DNAR) documentation, these were clearly identified at the front of people's care plans. Staff knew which of the people they supported had these forms.
● People's care documentation emphasised the importance of giving people as much choice and control as possible when providing end of life care.
● Staff told us about a person they had previously provided end of life support to. The person wanted to drink alcohol but staff were concerned this would interfere with their end of life medicines. A staff member said, "We spoke with the person's GP and they agreed it was alright and so the person was very happy."
● The registered manager told us about another person who was recommended a hospital bed as part of end of life support. The registered manager said, "The person refused this equipment because they wanted the comfort and familiarity of their own bed in the time they had left. We respected this decision."
● We viewed a thank you card received from a relative of someone who had passed away. It read, "Thank you so much for the care and compassion shown to my relative. The degree of care was so high that we had nothing to complain about."

Requires Improvement

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Requires Improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

At their previous inspection, A Plus Care Ltd were rated Requires Improvement with a breach of Regulation 17 in Well-led. This was because people's documentation was not always reflective of the care they received. There were no clear quality assurance processes to effectively manage the service and feedback was not sought to improve. Although we found improvements had been made by the registered manager to address these concerns, not all areas had actions taken. With the sudden departure of the registered manager, the provider did not always have complete understanding or oversight to manage in their absence. This is therefore the second time that A Plus Care Ltd have been rated Requires Improvement in Well-led.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;
Planning and promoting person-centred, high-quality care and support and how the provider understands and acts on duty of candour responsibility;
Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● We brought this inspection forward as we were made aware that the registered manager was leaving the service. They were present for the first two days of inspection. During feedback on the second day, we were reassured by the provider that they had contingency plans to manage the service when the registered manager left. This included bringing in an interim manager to support the service until a permanent replacement could be found. The provider was already advertising for a new registered manager. We agreed that we would visit for a third day of inspection after the registered manager's departure, to ensure the service was being managed effectively.
● Before the third inspection day, we were advised that the registered manager had left earlier than planned without supporting the interim manager with a handover. At this time, the care co-coordinator and three other staff also resigned with immediate effect. We therefore had concerns that staff remaining in the office did not have clear understanding of people, their support needs and processes. 11 people had also cancelled their care packages, some to follow staff that had left.
● Although the provider, business director and company administrator had worked hard to ensure people had consistent care, there were some areas where regulations were not being met.
● Two incidents which had placed people at risk of harm, had not been reported to us or the local authority. The provider was not aware that this was required nor how to complete the notification. Following discussion and guidance from us on the fourth day of inspection, these incidents were reported.

The failure to submit these notifications is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

● It is a requirement for services to display their current CQC ratings clearly and legibly. We spoke with the registered manager in August 2018 regarding their report rating not being displayed on their website. This was immediately rectified. Since then, the provider had changed the website, however they were still not displaying their current rating. By the third day of inspection, the website had temporarily been taken down. The provider advised that when it was reinstated, they would ensure their rating was clearly displayed.

The provider had failed to ensure that ratings from CQC were clearly displayed at all times. This is a breach of Regulation 20a of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We found that improvements had been made to quality assurance processes and people's documentation. However, not all concerns identified at the previous inspection had been addressed.
● The provider advised us that they had limited involvement with the service before the registered manager left. They were therefore not fully aware of previous concerns and the areas where action had not been taken.
● People who could display behaviours that challenged did not have positive behaviour assessments to advise staff what actions to take. This was identified at the previous inspection but had still not been addressed. The provider was not aware that this had not been rectified. We spoke with staff that visited these people and they had a good knowledge of how to support with their anxiety and behaviours that challenged. Therefore, we considered the impact on people to be low. However, the registered manager acknowledged that having this information in people's documentation was important to achieve continuity of care.
● Although people and their relatives had been sent surveys to gain feedback of the service provided, views from staff and professionals had not been sought. Information that had been received had not been fully analysed to identify patterns or trends nor feedback given to those involved. There was also a lack of evidence to suggest actions were taken to address concerns.
● Although no formal complaints had been received, concerns had been raised by people and relatives to the registered manager, whilst they were still in post. These had not been documented. This meant that there was not full oversight of concerns or actions taken to rectify them.
● Staff had not received regular supervision, team meetings or spot checks to monitor their practice and improve knowledge. Two staff members had only received one supervision and spot check in the previous year. Another staff member told us, "I don't remember the last time I had a spot check." It was acknowledged by the registered manager that this was an area for improvement. However, the provider had not been informed of this.

The provider had not ensured good governance had been maintained. Therefore, the above areas are a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● When we spoke with staff on the first two days of inspection, they were complimentary of the registered manager but concerned about how the service would be managed without them.
● Following the registered manager's departure, we spoke with three of the same staff. They told us there had been lots of changes but that, "The provider, business director and company administrator were doing the best they could." A staff member said, "I never really had a lot of contact with the provider before, but now the registered manager is gone, I talk to them all the time and they are really supportive." Another staff member told us, "I have to say they are pretty responsive. And they seem to really care about making things

right."
● Staff told us the interim manager seemed, "Knowledgeable" and "Efficient." They advised that if they had any concerns, they could report these to them, the provider or company administrator.

Continuous learning and improving care; working in partnership with others

● The provider, business director and company administrator worked hard to ensure people received care calls as normal, even with frequent changes to staff and care packages.
● The provider told us that they had, "Learned an enormous lesson" and would be, "Taking immediate action to improve oversight and ensure issues do not happen again."
● The provider told us of plans to improve their oversight of the service, such as monthly audits and meetings with the new registered manager.
● The provider was responsive to issues that we raised and had started to address some of these by the fourth day of inspection.
● The provider was keen to work with others to improve their knowledge of the regulations and their responsibilities. Immediately following the inspection, they started working with the Marketing Support Team from the local authority to improve areas of concern.

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 18 Registration Regulations 2009 Notifications of other incidents<br><br>The provider had not ensured that incidents where potential harm had come to people, had been reported to relevant others.<br><br>18 (2e) (2f) |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider had not ensured that care and treatment was provided with the consent of the relevant person<br><br>11 (1) (2) (3) (4) |

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 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had not ensured good governance had been maintained. Appropriate systems and processes were not in place to fully assess, monitor and improve the quality and safety of the service provided.<br><br>17(1) (2a) (2b) (2c) |

**The enforcement action we took:**

We have issued a warning notice. The provider must be compliant with this by June 2019.