St Georges Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

St Georges is a service which provides personal care and support to adults in their own homes. In addition to providing personal care, they also provide a companionship service which helps people with activities and help with domestic duties. This element of the service, although provided by St Georges would not need to be registered with the Commission if this was their sole purpose. We focussed our inspection on the people in receipt of personal care only. On the day of our inspection there were 39 people using the service, 35 of which received personal care.

The provider was given 48 hours' notice of our inspection because the location provides a domiciliary care service and we needed to know that someone would be available.

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

At our last inspection in July 2017, we found the registered provider was in breach of six regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to submit an action plan to tell us how they intended to make the required improvements. At this inspection, we checked whether these improvements had been made and found the provider continued to be in breach of one of these regulations. Progress had been made in meeting the requirements of the other regulations previously breached. However, further improvements were still required in some areas.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Georges on our website at www.cqc.org.uk.

Improvements were still needed in how the service assessed and recorded risks relating to people's specific health conditions and daily living. This included risks associated with the administration of people's medicines.

Despite the lack of information in people's records relating to management of risk, people indicated they felt safe with the staff providing their care and support. Staff were provided with training and guidance in how to keep people safe and what they should do if they were concerned a person was at risk or was being abused. Concerns and complaints were responded to appropriately.

Care plans had been updated and better reflected peoples support needs. However, further work was needed to ensure all aspects of peoples care and support were considered and that care plans were consistent and accurate. Despite some shortfalls in the care records, people and their families told us they received personalised care that was responsive to their needs and their views were listened to and acted on.

People were positive and complimentary about the care they received. They were treated with dignity and respect and independence was encouraged. People received support from regular carers and staff arrived when they expected them. There had been improvements in staff training. and people were confident in the ability of the staff.

Staffs understanding of the mental capacity act had improved and they understood the importance of gaining people's consent to the support they were providing. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. However, mental capacity assessments required additional work to ensure they were specific to individual's needs.

Guidance was available to staff regarding the support people required with their nutritional needs. People were supported to access services from health care professionals such as the community nursing team and GP's.

New quality assurance systems were not yet completely effective at identifying where improvements were needed. The provider lacked oversight and there was not a consistent and planned approach to monitoring the service provision. Opportunities to improve records and therefore improve the provision of care had been missed. However, people, relatives and staff fed back that there was an open culture at the service and could see improvements had been made since out last inspection. They were confident these improvements would continue.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Improvements were needed in the management of risks associated with people's specific health conditions, daily living and administration of medicines.

Procedures were in place to safeguard people from the potential risk of abuse.

People received support from regular carers and staff arrived when they expected them.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received the support and training they needed to provide effective care for people.

Mental capacity assessments required additional work to ensure they were specific to individual's needs. However, people received support from staff who respected people's rights to make their own decisions, where possible.

People were supported to maintain good health.

Is the service caring?

Good

The service was caring.

People valued the relationships they had with staff and were positive about the care they received.

People felt staff always treated them with kindness and respect.

People were supported to have choice and control.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans had improved but were not consistent and did not always fully reflect all of peoples support needs.

Despite the shortfalls in the care records, people and their families told us they received personalised care that was responsive to their needs.

Concerns and complaints were responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Quality assurance systems were not sufficiently robust to ensure the registered provider was operating within expected standards of governance and ensuring effective oversight of the service.

People, relative and staff fed back that there was an open culture at the service and were confident improvements would continue to be made.

St Georges Ltd

Detailed findings

Background to this inspection

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

The inspection took place on 7 December 2017 and was carried out by two inspectors. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone was available to speak with us.
Before our inspection, 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.

We also reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We looked at the care plans of six people and four staff files; we also reviewed records about how the service was managed. These included medicine records, staff training, recruitment and supervision records, accidents, incidents, complaints, quality audits and policies and procedures.

Reviewing these records helped us to understand how the provider responded and acted on issues related to the care and welfare of people, and monitored the quality of the service.

During our inspection, we spoke with the registered manager, six members of staff, three people who use the service and four relatives.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in July 2016, we found the management of people's medicines required improvement. At this inspection, we found that although some improvements had been made in relation to training and observation of practice there were still areas where additional work was needed. Staff had taken part in additional training and observational supervision to provide them with the knowledge they needed to assist people with their medicines. However, care records still did not clearly demonstrate the level of support people needed with their medicines.

One person was prescribed pain relief on a 'as required' basis which their care records stated, 'can be offered if displaying signs of being in pain or if [person] requests it.' A member of staff told us that although the person could express they were in pain they may not associate this with a need for pain relief. There were no details in the care records to indicate how the person may display signs of being in pain so staff would know what to look out for. The care plan said staff should record the reason for the medicine being given in their visit log but no reasons had been recorded. The medicine had been given five times in September but no doses were recorded as being given in October. An entry in the records for September showed that supplies of the medicine had run out and there was no subsequent entry to show when new supplies had been made available. It was not clear whether staff knew when to prompt the person that they may need pain relief, whether there was any pattern to their need for pain relief or whether it had been available when needed. The provision of this medicine had not been consistent and put the person at risk of unnecessary pain.

Another person's care records indicated they were able to administer their own medicines. However, their care plan also stated that they required staff to prompt medication, as they were unable to see labels clearly. The level of support required was unclear and records did not demonstrate how much staff had been involved. This meant the appropriate level of support may not be provided, putting the person at risk of not receiving the support they needed with their medicines.

Information for staff regarding specific medicines, which needed to be taken or applied in a particular way, were incorrect or lacked detail. One person was prompted to take an Alendronic acid tablet weekly. These type of tablets should be taken at least 30 minutes before food or other medicines to ensure they are effective and the care plan stated, 'nothing to eat or drink for 30 minutes after taking.' However, this guidance could be confusing for staff as it is important that plenty of water is available when taking this medicine. Further important information was not included, such as following administration people should not lie down for at least 30 minutes to prevent irritation of the oesophagus (food pipe). Another person was prescribed a pain relief gel to be applied to ease localized joint pain. However, the guidance to staff stated to apply 'evenly on the bottom.' We discussed this with the manager who acknowledged this information was not correct and would be amended immediately. Without the appropriate guidance for staff, people were at risk of receiving their medicines in a way which could limit their effectiveness or cause harm.

Risk assessments relating to peoples medicines were generic and we found several records for a number of people that mistakenly included the same name and information. One person's care plan who was at high

risk of seizure showed they were allergic to many different types of medicines including some which may be administered in the event of a seizure. This person's family administered all of their medicines. However, they were occasionally supported by staff outside their home. The person or staff did not carry details with them regarding these allergies should support be required from emergency services if the person became very unwell whilst out. This showed a personalised approach had not been taken in establishing risks specific to each individual in relation to medicines management. This could mean potential risks to people were not identified or managed effectively.

Improvements were still needed in how the service assessed and recorded risks relating to people's specific health conditions and daily living. Care records did not include detailed risk assessments to provide staff with guidance on how the risks to people were minimised. For example, one person required all fluids to be thickened to prevent the risk of them choking. They were mostly supported with this by their family. However, there was no guidance for staff to show how this should be managed when they were supporting the person away from their home, which they did on occasion.

Another person was diagnosed with diabetes and was known to often make decisions about their diet which may be considered unwise. The person had the mental capacity to be able to make these decisions for themselves but this put them at risk of harm due to the effect these food choices could have on the management of their diabetes. The persons care plan did not contain a risk assessment specific to the individual giving staff details of these risks, what signs they should look out for which may indicate the person's blood sugar level was dangerously high or low and what action they should take in these circumstances.

One person had an in-situ catheter and their care records started staff should note the colour of urine to allow the community nursing team and family to monitor. Staff had done this but there was no risk assessment or details to inform staff when they may need to take action due to concerns relating to management of the persons catheter. For example, urine output that is consistently different to what is normal for the person or details of what may indicate a blockage, which could lead to severe pain, discomfort and infection.

The senior team had identified some shortfalls in care records but it was unclear how they had used the lessons learnt to improve the quality of the service provision. For example, audits showed that staff needed to make sure peoples medicines records were updated when there were changes to the medicines prescribed. However, the progress in relation to this had not been recorded and there was no mention of the issue on the following months audit. Without clear action plans to reduce future risks, opportunities may be missed to identify further concerns and make any improvements needed.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.□

Despite the lack of information in peoples records relating to management of risk, people indicated they felt safe with the staff providing their care and support, Staff understood their roles and responsibilities regarding safeguarding people and protecting them from harm. They were able to demonstrate how to report concerns should they see or hear anything which concerned them. One member of staff told us, "I would report [any concerns] and you would like to think they would act on it. If it wasn't getting dealt with here I would go to the next level. I'd be getting on to social services."

Most people told us they consistently received support from regular carers and staff arrived when they expected them. One person told us, "I've got regular ones [staff] who come to me. Mostly at weekends I have

different ones but I do know them too." Another person said, "I get a roster for the weekend and for the week. They let me know who is coming." However, one relative felt that communication regarding the weeks rota could be improved on, "We fight to get the rota for the week. We get it Friday for the following week. Having a regular carer is better. If someone came in my [relative] didn't know they [relative] would say they didn't need help. There are a nice set of carers but you don't always get the continuity you would like."

The registered manager explained how each person's call was at least an hour and people confirmed this to be the case. One person told us, "An hour they come for and it takes them all that time. Sometimes they run over. They do all that is needed."

The registered manager told us how recruitment of new staff continued to be difficult although staff retention was good once employed. One relative explained what the shortage of available staff on occasions had meant for them when requesting an additional visit, "We don't always get a carer for teatime. They are short on [staff] in cars." However, they were very positive about the support provided by the staff and were informed when a member of staff was not going to be available. Another person told us, "We've only had one problem of them not turning up. They always phone ahead if there is a problem." Staff told us how they worked together to try to cover shifts wherever possible, one told us, "We are always short on staff. Otherwise, it is all right. I'm always working extra hours." They went on to explain how they were happy to pick up the extra hours when needed.

Recruitment processes were in place for the safe employment of staff. The service checked the applicant's identity, right to work and carried out disclosure and barring checks (DBS.) This meant they made sure new staff were safe to work with vulnerable adults.

Staff were trained with regard to infection control and staff confirmed supplies of personal protective equipment such as aprons and gloves were made available to them. Care plans could be strengthened with the addition of information to guide staff how to ensure they prevent the spread of infection when disposing of continence pads or cleaning commodes for example.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in July 2016, we found staff required additional training in some areas. At this inspection, we found improvements had been made to the way training was managed so the registered manager was able to identify when staff needed training. A member of staff told us, They always send a letter when training is due. They are hot on that." Staff had completed additional training in relation to specific healthcare needs such as diabetes, epilepsy and catheter care. A relative told us, "[Staff] are very well trained. Really good." A member of staff commented, "We get training in all aspects of care, maybe twice a year, health and safety, dementia, food hygiene, all the aspects that cover the job. If there are any issues, they are more than happy to give me a bit extra. For example, I hadn't done hoisting for a while so they gave me an update."

Medicines training had been developed further and staff were asked to complete additional training when observational supervisions or monitoring of medicines records highlighted their knowledge needed to be strengthened. A member of staff confirmed, "Medicines, we've had a lot of training." One of the care co-ordinators explained how additional training had been arranged when it was noticed staff were not consistently recording the administration of topical medicines such as creams. However, the shortfalls we found in peoples care plans regarding management of their medicines showed the provider had failed to monitor whether the training provided was being effective in improving care records and therefore people's quality of care.

New staff were required to complete the care certificate. This is an identified set of standards that health and social care workers adhere to in their work. A care co-ordinator explained, "[New staff] are not offered work until they've completed the training." Following their induction staff continued to be regularly supervised and observed carrying out their role to ensure they provided support to people in line with best practice guidelines. A person told us, "[Care co-ordinators] come from time to time to check on the carers. Every few months they come." A member of staff confirmed, The care co-ordinator comes out to see how things are going. That everything is going alright and the service user is happy." Another member of staff said, "We are well trained. [The care co-ordinators] always give us advice and they are always in touch with families to ask if everything is ok."

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

At our last inspection in July 2016, we checked whether the service was working within the principles of the MCA. We found staff could not explain the principles of MCA and how they may need to apply this in their day-to-day role. There had been improvements in this and all staff had a better understanding of the MCA.now received MCA training. A member of staff explained, "Capacity. It is already assessed. It is in the

care plan." They went on to say, "I always ask permission and respect privacy." A person confirmed, "Whatever they've got to do they always check first if that's ok. They say, 'I'm going to do so and so, alright?' They let you know."

However, although staff knowledge had improved in relation to MCA this was not reflected in peoples care and support records. Mental capacity assessments had been completed but the exact decision to be made was not always specified and the action to be taken was not specific to individual's needs. For example, one person's care records contained an assessment that had been ticked to show it was in relation to a number of decisions, including washing, showering, nutrition, changing incontinence pads and prompting with medication. A person may have varying capacity to make decisions about different elements of their care so these should be assessed separately. Another person's care records contained an assessment relating to personal care but the section of the form to indicate the exact decision to be made had been left blank. Without correct assessment and demonstration of how decisions had been made in people best interest, people were at risk of staff assuming they were unable to make any decisions for themselves and not providing the right level of support.

People's preferences about the care and support they received had been considered and taken into account. For example, care records showed whether people had a preference with regard to the gender of their care worker and people confirmed their wishes were respected in relation to this. A member of staff explained how they could only provide support for certain people because others had indicated they would prefer not to receive care from a particular gender of staff.

There was good communication between the staff team which helped to ensure changes in people's needs were passed on and helped staff to get to know people well. A member of staff commented, "One of the most important parts of the job is communicating constantly." They explained, "If there are concerns they do get notified. We had a [person] this week whose mobility was iffy. They were unsure of getting from A to B. I raised a concern." They went on to explain how changes had been made to accommodate the person's needs.

Staff were provided with guidance in people's care plan's regarding the support people required with their nutrition. This included people's preferences and actions staff should take to support them to eat and drink. For example, one person preferred staff to ensure their lunchtime meal was available for them to microwave themselves later. Their care plan guided staff to prompt the person to eat this main meal later in the day if they hadn't eaten it at lunchtime. This demonstrated people were being supported with their specific dietary needs and were given the opportunity to express their preferences in relation to what they would like to eat and drink.

People were supported to access services from health care professionals such as the community nursing team and GP's and involved families where appropriate. Staff demonstrated knowledge of the additional support being provided to people by the community nursing care team and how this related to the care they were providing for people. However, this was not fully reflected in peoples care plans. One person's care plan stated that the community nursing team were involved in treating an ulcerated leg. However, there were no further details to show for example, how this impacted on the person's life or if it caused them any pain. Where staff had been asked to record details about urine output for a person with a catheter it was unclear how this information was passed on to the community nursing team or how staff should report any concerns.

Good

Is the service caring?

Our findings

At our last inspection, we found people's care was not regularly reviewed and they and their relatives were not always involved in this process. There had been improvements in this. One relative told us about reviews which took place regularly and involved them as well as the person, "We both do the review together. They make sure that I'm going to be here." Another relative commented on a person's care plan, "It feels accurate. It's been checked over and they do amend it if needed. There is a big improvement in paperwork." A third relative said, "They do involve us it's something they've improved on."

People were positive and complimentary about the care they received. One person told us, "They are all very good. Very nice and pleasant. Whatever is needed to be done they do." A relative commented, "They are very polite and very efficient. I don't know how they have so much patience. I didn't know care could be that good." Another relative said, "The [staff] that come are fabulous."

People, wherever possible were encouraged by staff to make decisions about their care, support and daily routines. A member of staff commented, "Everyone is an individual. They like choices. You give them options. Then they are making the decision rather than you telling them what to do." This demonstrated staff were guided by the wishes of the people they were supporting and encouraged people to have independence and control.

Staff had a good knowledge and understanding of people's preferred routines, likes and dislikes and what mattered to them. A relative said, "[Member of staff] is excellent. They treat [relative] like their own [relative] All in all an excellent service. Its evidenced by that [relative] is better than [they] were a year ago. They are very flexible. If we say we need an extra hour [member of staff] is there. They are very very good. I think [member of staff] gives a bit more than they have to. It's part of looking after the family as well. [Member of staff] goes over and above. It puts our mind at ease."

People had regular carers who they had built a relationship with. One person told us, "I've got a lot of regulars. I get to know them." A care co-ordinator explained, "We try to match clients to staff. You get to know who will suit. Some staff talk more than others, some clients like a lot of that some don't. It's all based on client's preference. We try to accommodate. We have one client who speaks [language other than English] They enjoy having a carer who can also speak [language] it works well."

People were encouraged to be independent where possible and to be in control of the support they received. Care plans contained helpful guidance for staff to help achieve this. For example, details regarding support required with continence products and how staff should do this in a way that promoted independence whilst maintaining a person's dignity and privacy. A member of staff told us how they had been working together with a person to promote independence in relation to personal care. "We now have a routine where they are happy to shower one day and wash one day. I've encouraged [person] stood back and let them do it."

People's privacy and dignity was promoted and respected. A member of staff commented, "You go with

what they want. Respect is the biggest word in my language. I try to give the best possible care. If you can make a difference that's why you do it." A relative explained how staff always treated their relative with respect, "What [relative] likes is that [member of staff] talks to them not at them. [Relative] looks forward to [member of staff] coming. It's a five star recommendation." This demonstrated staff recognised the importance of privacy and dignity as core values and worked together with people to promote them.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, we found the service had not always been responsive to people's needs. There had been improvements in this and changes in peoples care needs were communicated to staff and reflected in care plans. A member of staff told us, "Any changes that occur I would come in to tell office. They would go out to reassess. One of them in the office would phone and tell us if there is any change. They are supportive here." Another staff member confirmed, "Any changes, they always send a message saying please check the care plan."

Care plans had been updated and better reflected peoples support needs. A member of staff told us, "It's all been updated. They are still changing bits and pieces. There is enough information. At one time I did say it needed to be clearer. Now it's all there." However, our review of the care plans and discussion with staff in the office demonstrated this was a work in progress and care co-ordinators were continuing to update and improve people's records to ensure they covered all aspects of their care and support needs, both physical and emotional.

There was little information relating to the emotional and psychological needs of people. For example, one person's care plan had been updated to show visits had increased due to changes in support needs. However, key details about the person's relative who had lived with them until recently were not included. This meant staff who were new to the service may be unaware of this relationship and the emotional impact it may have on the person. Further work was needed to demonstrate how the service responds to individual's differing care needs in terms of interests, emotional support needs and types and stages of dementia. This would further strengthen the care records to show how people's whole well-being was being considered and provide additional guidance to staff to ensure a holistic approach to people's care.

Care plans did not always record the level of support each person required with their medicines. This had also not been formally assessed to establish whether people needed to be prompted, observed or assisted with taking their medicines. The lack of clear guidance meant that any staff who were not familiar with the support needed would be unaware the level of assistance to give. This may mean people who were able to take their medicines independently were not given the opportunity to do so or that people were not receiving enough support to take their medicines safely and as prescribed.

We found some care records were not always consistent. For example, one person's care records indicated in one place that they required assistance with eating but in another place staff were not guided to provide this support. Some care records contained information relating to another person where details had been copied and pasted into the document. This could have been confusing for staff and meant people were at risk of not receiving care and support appropriate to their current needs. We discussed this with the senior team and they agreed that now the care records had been put into their new format there was a need to thoroughly review each one to ensure consistency.

Care staff demonstrated they were given opportunity to find out about a person's care needs before providing support. A member of staff told us, "First thing I do if I've got someone new. I go in the office and

they tell me about them before I go. I read the care plan and look through it at their house as well. I make sure before I go." Another member of staff told us what they did when going to someone they hadn't supported before, "I like to look at the comments of someone who goes there regularly. A combination of what is in the daily log and what is in the care plan.
It's good to look at people's history. You can see things which ring a bell and clicks with them. It's a good start. It gives you a good idea. It's never like you are going in blind." A relative commented, "Carers are aware more of the book (care plan) than before. They are putting the effort in. Most people that are new ask to see it."

People told us they knew who to contact if they had any concerns or complaints. People and their relatives told us concerns were usually responded to appropriately. One relative told us, "I've never had any complaints. They keep me very well informed." A member of staff commented, "They are supportive when something is wrong. They don't ignore things." However, one relative felt that although concerns regarding a person's care were responded to promptly this didn't always extend to concerns raised in relation to admin tasks such as issuing of rotas. They told us, "They listen. Sometimes they will act on it. If you've got problems in the home, they would deal with it immediately. Problems in the office I'm not so sure." Records showed concerns and complaints had been promptly acknowledged, listened to and appropriate steps taken to respond and put things right.

The service was not currently supporting anyone who was deemed to be at the end of their life. However, people's wishes relating to the care they would receive when this time came had not always been appropriately explored or documented. One person's care records stated they did not have a DNACPR (Do not attempt cardiopulmonary resuscitation) document in place but they had stated verbally they would not wish to be resuscitated. This information is misleading to staff and may mean the persons wishes were not carried out in the event they suffered a cardiac arrest. The purpose of a DNACPR decision is to provide immediate guidance to healthcare professionals on the best action to take (or not take) should the person suffer a cardiac arrest. Without this document in place healthcare professionals would commence CPR as there would be no supporting evidence to indicate this was not the person's wishes. This document needs to be completed by a senior clinician who is qualified to do so such as a GP or hospital consultant. The registered manager acknowledged the wishes the person had stated verbally needed to be discussed further with them and the relevant senior clinician and a DNACPR document completed if appropriate. This would ensure staff and others attending in an emergency situation, such as paramedics, would have the appropriate information to follow the persons wishes.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, the provider was found to be in breach of Regulation 17, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because, although we had received positive feedback regarding the leadership of the service, robust systems were not in place to monitor the quality of the service provided.

At this inspection, the senior team were able to show us the additional control measures they now had in place to monitor and assess different elements of the service such as medicines and care records. However, these new systems were not yet completely effective as audits had not been completed consistently and had failed to identify some shortfalls, such as gaps in care records or details regarding people's medicine requirements. Audits of people' medicine administration records had improved and these had identified issues such as staff not signing when creams were administered. Action had been taken in response to this in the form of additional staff training. Additional work was needed to ensure quality assurance systems were robust and potential shortfalls were identified and responded to.

The care-co-ordinators were responsible for care plans and the registered manager told us they looked at these from time to time to check on quality. They commented, "[Care co-ordinators] should be at a certain standard. They've all been trained." However, this assumption and lack of a planned and consistent approach to monitoring meant shortfalls had not been identified. This meant opportunities to improve records and therefore improve the provision of care had been missed.

The provider encouraged the registered manager and senior team to have autonomy in the running of the service. There were no records of any provider audits and this demonstrated that the provider lacked insight into areas where improvements were needed. Registered providers have a responsibility to ensure that quality assurance systems and processes should be continually reviewed to make sure they remain fit for purpose. This means they should ensure the systems in place identify where quality and/or safety are being compromised to enable them to respond appropriately and without delay. Lack of oversight meant the provider had not monitored whether the quality assurance systems in place were effective in identifying shortfalls, lessons learnt from them and action taken to put things right.

At our last inspection, we found feedback had not been gathered from staff in the form of staff surveys or at staff meetings. At this inspection the registered manager told us attendance at staff meetings continued to be poor. However, minutes of one meeting did evidence feedback from staff had been taken on board and action taken. Staff had raised concerns regarding time allowed to travel between calls and it had been agreed to change rotas slightly to accommodate suitable travelling time. A member of staff confirmed this had happened to ensure people received support for the full allocated amount of time, "The majority of my calls are within a 10-15 minute radius. It's better now. I did bring up about calls running one after another but now mostly there are gaps to travel. I manage it fine." A staff survey had also been carried out and where staff had indicated an additional training need this had been addressed.

Service user surveys had been carried out and the results analysed. Actions taken as result of the feedback

had been recorded which was an improvement on the findings of our last inspection. However, there were some answers to questions where it was unclear what action had been taken as a result. For example, the analysis showed two people had disagreed that staff explained to them what is meant by a safe service and how it made them safer. Two people had also disagreed that staff had shown them how to raise concerns about their own safety. The analysis of this feedback did not demonstrate that action had been taken to address these concerns. We discussed this with the registered manager who explained feedback was anonymous so it was therefore difficult to follow up specific concerns. However, the outcome of the analysis had been recorded as, 'concerns are always recorded and looked into.' This did not address the issue and there was no evidence of action such as ensuring how to raise a concern was explained to all people supported by the agency to aid their understanding of this.

Staff told us they were encouraged and supported by the senior team. One member of staff told us "It's a very good agency. The boss is brilliant and very supportive. They are like my family." Another member of staff commented, "They listen to you, they understand. [Registered Manager] is always available if needed." Staff also told us how they were encouraged to report any issues of concern and explained they understood the provider's whistleblowing procedures and how they would be supported with these. This demonstrated staff were confident they could raise any concerns and that these would be dealt with appropriately.

One of the care co-ordinators explained how they worked together with other health and social care professionals to enhance the service they provided. This included the community nursing team, dementia nurses, diabetic nurses, teams specialising in learning disabilities and social workers. Another care co-ordinator gave an example of how they had worked as part of a multi-disciplinary team to resolve an issue regarding medicines wrongly prescribed when a person was discharged from hospital.

People, relative and staff fed back that there was an open culture at the service and could see improvements had been made since out last inspection. They were confident these improvements would continue and be sustained. One relative commented, "Compared to [previous care provider] it's been fantastic. Another relative said, "The boss is very nice. Very good and keeps their eye on things. Top management is excellent. They are trying to do their best. I'm sure things will only get better." This demonstrated that management and staff were committed in their approach to continue to make the changes needed to ensure all people's care and support needs were being met. The senior team were working with staff to help them to understand and share the culture, vision and values of the service in its main objective to provide high quality care and continued positive life experiences to those who used it.

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 12 HSCA RA Regulations 2014 Safe care and treatment Improvements were needed in the management of risks associated with people's specific health conditions, daily living and administration of medicines.