SCC Agency limited

SCC Agency Ltd (trading as South Coast Care)

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?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 7 November 2017 and was announced. The service is a domiciliary care agency which provides personal care to approximately 115 people living in their own homes in the West Sussex areas. The agency supports a range of people living with a variety of identified needs, including those who may be living with dementia, mental health, older people, younger adults, people living with physical disability and sensory impairment. People living with eating disorders or who may misuse drugs and alcohol may also be supported by this agency. The registered manager told us that the service was able to provide people with care at the end of their lives.

Not everyone using South Coast Care Limited receives personal care services. The Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

There is a registered manager at this service who has been registered with the CQC since April 2013. A registered manager is a person who has registered with the CQC 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. The registered manager is also the registered provider for this agency.

The agency was previously inspected by us in October 2015 when they were rated as providing a good service to people. However, during this inspection on 7 November 2017, we found that the registered manager was unable to sustain this level of good practice. We previously had concerns about this provider's ability to run a good service. In January 2015 we rated this provider as inadequate overall, with breaches of regulation in eight areas. Two of these breaches resulted in us taking enforcement action against the provider. We had significant concerns about the quality of service provision and the provider's ability to have clear oversight and regular monitoring of the service. Other concerns related to poor medicines management, lack of detail in people's care plans and risk assessments to mitigate risks to people. Staff were not completing mandatory training and there was a lack of staff supervision and poor management understanding of the Mental Capacity Act 2005 and how this affected their provision of care to people.

In May 2015 we completed a Focused inspection to review the provider's progress against the previous concerns. We found that the provider was still providing an inadequate service in relation to the assessment of risks and completion of appropriate risk assessments for people. People's medicines were still not being managed safely. There had been some improvements in the provider's quality systems and it was noted that medicines audits were being completed by the registered manager. Despite the service being rated as good overall in October 2015, in November 2017 we found that this had not been sustained. The registered manager was not completing any audits to monitor the quality and safety of the service provided to people.

People's safety was compromised in some areas. Risks to people weren't always clearly identified, assessed

or managed safely and actions were not always recorded for care staff to be able to reduce the risks. Accidents and incidents were not always recorded appropriately and risks identified were not always assessed with sufficient detail to mitigate identified risk as part of the person's care plan. Records relating to medicines for people weren't always completed accurately. However, people using the service told us that staff administered medicines appropriately to them and that they felt safe.

Care plans did not always reflect people's individual needs clearly and the specific support that would be required to meet people's needs, choices and preferences were not clear in most care records seen.

There were enough staff to provide care to people. However, some people said that they did not know when they would be seen by staff and stated that the management of the service wasn't always efficient. People knew how to raise a complaint if they needed to. The service had no records of complaints at the time of the inspection.

The management team did not have sufficient knowledge and understanding of how the Mental Capacity Act 2005 affected their provision of care to people. This may place people who lack capacity to make decisions at risk of not receiving the support they require in order for care to be provided in their best interests. People's health was monitored in daily records. The agency used an electronic system which enabled the duration of calls and staff whereabouts to be tracked to support the safety of staff that may be lone working and to provide confirmation of the care people received.

Staff received training to cover a range of subjects including health and safety, medicines, moving and handling, safeguarding, and infection control. Some additional specific training had been listed within the staff training logs, which included training for people's particular care needs. However, not all staff had completed the training required and there were gaps in staff training records. Staff had not all completed food hygiene or first aid training. This may result in people not receiving safe and effective care from suitably skilled and trained staff. Staff did not all receive regular supervisions and observed practice sessions. Staff were aware of how to report safeguarding concerns.

During the inspection we found that the provider had not submitted statutory notifications to the CQC when they are required to. The registered manager was not aware of their responsibilities and requirements under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009 to notify the CQC.

Quality audits of the service were not being completed when this inspection was conducted, but some people using the service could recall being asked for their views of the service. Records showed the registered manager communicated regularly with staff electronically using a secure system, regarding updates and changes staff needed to be aware of. Staff spoke positively about the management of the service and felt supported in their roles.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009. You can see what action we have taken at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The 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.

Accidents, incidents, risks to people and records relating to peoples medicines were not always assessed and documented accurately.

Staff had not all received all mandatory training when providing personal care to people.

There were enough staff.

Staff had enough protective equipment.

Arrangements for involving and informing all relevant partner organisations of safeguarding and other incidents were not in place.

Is the service effective?

Requires Improvement

The service was not always effective.

Management lacked an understanding of the Mental Capacity Act
2005 and how the principles could affect their treatment and the assessments they could complete for people who may lack the capacity to make decisions.

Staff did not always have the relevant skills, knowledge and experience to deliver effective care and support to people.

Staff sought verbal consent from people before supporting them with personal care.
People's health was monitored and staff sought advice and guidance from professionals as people required to meet their needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People's communication needs were not always clearly assessed

or recorded.

The staff were kind and caring and people were treated with compassion.

People were asked about their views of the service and the care they received.

People's privacy, dignity and independence was respected and promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans did not always reflect their physical, emotional and mental health needs and people didn't always know when they would be seen by staff.

People knew how to raise a complaint and were confident to do so.

People were supported compassionately by staff at the end of their lives.

Is the service well-led?

Inadequate

The service was not well-led.

The service does not have a clear strategy or vision and does not always share information in a transparent way with other relevant organisations.

Systems to manage the overall quality and governance of the service are not robust and changes to practice following feedback are not maintained or sustained. Records of risks are not robust and regulatory requirements are not always understood and managed by the provider.

People's views have been sought about the service they receive but there is no evidence to show how people's views change the service provided.

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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 7 November 2017 and was announced. The provider was given 48 hours' notice because the provider is a domiciliary care agency and we needed to ensure that staff were available in the office to be able to conduct the inspection. The inspection team consisted of two adult social care inspectors and an Expert by Experience. This is a person who has personal experience of using or caring for someone who uses this type of service.

Before the 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 previous inspection reports and any notifications received from the service before the inspection. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We spoke with six members of staff including the registered manager, deputy manager, office administrator and three care staff. We spoke with 13 people who used the service and their relatives, to seek their views. We also spoke with external health and social care professionals, including a Continuing Healthcare (CHC) nurse a social worker and a member of the local authority's contract monitoring team.

We reviewed the records for seven people's including care plans, risk assessments and other associated records. We looked at six records relating to the recruitment of staff, staff training, supervision and appraisal. We reviewed records that monitor the quality and safety of the service including audits, satisfaction surveys, complaints and other records to assess the providers understanding of regulatory requirements. We also

sampled some of the services policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Medicines weren't always given to people safely. Whilst staff had received training in the administration of medicines, there were no systems to monitor staff competency in this area. There were no systems to audit or monitor Medication Administration Records (MAR) so if errors had occurred there was a potential that they might not have been identified. For example, medicines records for one person were not accurate with no clear instruction for staff giving medicines. There were two duplicate medicines risk assessments for this person which contained the same information, including the same date, but the prescribed medicine for this person was different on each assessment. Staff did not have clear instructions about the correct medicines to be given to this person. One of the medicines assessments stated that the person was to take a medicine in the morning only and the other assessment stated the medicine was to be given in the morning and evening. We also looked at the MAR for this person which indicated that the person had been given the medicine at a dose of 5mg each morning for one month and then at a dose of 5mg each morning for seven days of the following month which then increased to the medicine being given twice a day. The medicine prescribed was a beta-blocker medicine, usually prescribed to reduce blood pressure. The information on the medicines assessments did not include details of this persons medicines being reviewed. No instruction of when the dosage was changed by the person's GP to a higher dose was recorded on the assessment form. This means that the person may not be receiving their medicines safely as prescribed. The registered manager could not provide sufficient explanation as to whether this person had received their medicines safely and as prescribed. The registered manager stated they would investigate this. Following the inspection we contacted the registered manager to ask them for the outcomes of their investigation as we had not received this. We were told that a senior member of staff had photocopied the initial medicines assessment instead of completing a new assessment and added the additional evening medication to the photocopied assessment form. The registered manager stated that the records in the person's home were correct and that no medicines error had occurred. We could not be assured of this with the evidence we saw.

A member of staff had decided not to apply a prescribed cream for one person as they didn't believe the person required the cream. The record stated that a staff member had chosen not to apply a prescribed cream for a person and that they believed if applied too often it would do 'more harm than good.' This had not been followed up and no action had been taken by senior staff. This was discussed with the registered manager who told us they did not know about this. This demonstrated that staff did not always know when to refer to appropriate healthcare professionals for advice and guidance about people's medicines. This could place people at risk of receiving unsafe care and treatment. We asked the registered manager to investigate this. Following the inspection we asked the registered manager for the outcomes of their investigation as this had not been provided to us. The registered manager stated that the cream was prescribed for the person on an 'as required' basis and that the member of staff had had additional medicines training following the incident. The registered manager had not identified that staff should not be making decisions regarding when to apply people's prescribed cream without the advice of an appropriate healthcare professional prescriber and should be following a clear plan of care and 'as required' protocol for when this is required. There was no clear plan of care for when this person may require the cream and placed the person at risk of unsafe care.

People and staff were not protected from the risks of people falling. The risks of falls were not recorded in the care plans for some people who had been identified as being at risk of falling. The registered manager told us some people were at risk of falling and stated there was no monitoring of falls within people's records. Staff had not received training regarding falls prevention. One person's risk assessment stated that the room they spent most of their time in was "a little cluttered". The assessment identified that there were trip hazards within the environment, but no action's had been taken to reduce the risks to people. The management of risk is an area that continues to be unsafe as identified in our inspection report following the inspection completed on the 8 and 15 January 2015.

People were not always protected from the risk of reoccurrence of harm. Lessons were not always learned nor improvements made when things went wrong. Accidents and incidents were not recorded or monitored in a consistent way, nor were they analysed for any trends and preventative measures that may be taken to minimise risks of avoidable harm to people. The registered manager told us that they didn't complete any audits and that there was no action plan for the service or for people to capture and analyse this data. This meant that any analysis of trends or reoccurring errors may not be appropriately monitored to highlight and reduce risks where possible to prevent them from happening again. In January 2015 we inspected this service identifying the same concerns. The report following the inspection of the 8 and 12 January 2015 stated "risks were not assessed accurately and action was not recorded for care staff to reduce the risk". This indicates that the registered manager is unable to sustain the improvements that were noted in the report following a further inspection conducted on the 20 August 2015.

People were not always supported to manage their behaviours. Some people had behaviours that may challenge such as living with dementia, anxiety and diagnosed mental health conditions including obsessive compulsive disorder (OCD). Person centred assessments were not completed to provide sufficient detail and guidance for staff to support people's needs in the way they may choose. Staff did not receive specific training to support them to manage behaviours that may challenge. Records for one person who experienced anxiety showed limited advice to guide staff on how to reduce the person's anxiety. The registered manager told us they received many telephone calls on a daily basis from this person presenting in an anxious way. There was no plan to offer consistency in approach to support the person with this assessed need and this left the potential for an escalation of their anxiety. Another person had a diagnosis of OCD and anxiety. There were no person centred behaviour strategies or plans for staff to offer support to this person. The assessment for this person said "do not rush". This was the only guidance provided to staff. This may result in behaviours not being managed in a person centred or safe way for this person.

There was a risk that people may receive unsafe care and treatment because risks had not been assessed and managed appropriately and staff were not always suitably trained to meet people's needs safely.

The above is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were safeguarded from abuse as staff were suitably trained to understand how and when to refer safeguarding concerns to the local social services department or their line manager. The deputy manager told us that the staff followed the West Sussex policy on safeguarding. This was available online for staff as guidance for dealing with any such concerns. Staff and the registered manager told us they had received training to enable them to identify when people may need safeguarding from abuse. Staff were able to tell us how they would report safeguarding concerns to their manager or other appropriate agency. People told us that they felt safe. One person said, "safe oh yes yes. I've had them some time. They do my medication and put it in my care plan on the chart. I have three carers they always introduce themselves. I feel very comfy with them."

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role. Staff were recruited in line with safe practice and staff files confirmed this. For example, employment histories had been checked, references obtained and appropriate checks undertaken to ensure that potential staff were safe to work with adults at risk. Staff records showed that, before new members of staff started working at the service, criminal records checks were made with the Disclosure and Barring Service.

Sufficient supplies of protective equipment for staff were stored in the office. This included gloves and aprons to support the management of the risk of infections to people.

There were enough staff to meet people's needs. Staff told us that there were arrangements in place to ensure that they provided regular care in a consistent way to people. Staff felt that they had sufficient time to travel between visits to people. People did not have any complaints about the safety of the care provided to them or their loved ones. One person said; "there's always plenty of nurses and carers. I'm very independent".

Requires Improvement

Is the service effective?

Our findings

The registered manager told us that people's care needs were assessed before they received care. This helped to ensure the staff could meet people's needs. The service had a copy of the assessment carried out by people's social workers. However, assessments contained conflicting information. For example, one person's records contained four different lists of the calls required. It was unclear from the records whether the person was receiving a lunch time call. The records stated that the person received personal care, but there were no details of what this meant. This was discussed with the registered manager and deputy manager who were also unclear about the required level of care required for this person from looking at the records. People's care plans were brief and did not give staff sufficient detail for staff to be able to ensure consistent care.

People did not always receive a consistent service by well trained staff. Staff said that they knew people well and people said that they were usually happy with the care they received from staff, although one relative said they "Don't always know who's coming. The younger ones haven't always got the experience. Think the regulars are trained enough. The new ones just turn up no introductions. The regulars are generally very good and effective" This was reflected in the training records that we saw which indicated that not all staff had received essential training. A member of staff told us that they hadn't received any supervision since they started working for the agency. Staff also told us that they weren't always introduced before visiting people for the first time.

People and their representatives, when appropriate, were not always involved in the reviews of care for people. The registered manager told us that people's health and care needs were reviewed on a six monthly basis. People's preferences regarding how they would chose to be involved with the reviews of their care were not documented within their care plan and assessment records. Some people told us that they were involved in reviews of their care. We saw a review record for one person containing limited information about the care they received. It had been documented that the person receiving care had said "I am happy with the level of care I currently receive". We were told by the registered manager that they liaise with other health and social care professionals to support people to live within their own homes. They explained how the agency works with 'dementia crisis' teams and social services to support people who are living with dementia. We did not see records of people's consent being obtained regarding referrals to healthcare professionals, nor of the person being involved in decisions about their healthcare needs. People may not always receive care and treatment in line with their personal choices and preferred outcomes.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack 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. The MCA Code of Practice states that a person's capacity must be presumed unless proven otherwise and that assessments are time limited and decision specific. When a person may 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.

The registered manager told us that staff had completed some basic awareness training for MCA. The registered manager sent us information following the inspection to show they had completed an MCA Train the Trainer course. Train the Trainer courses provide people with the skills and information required to train others in the subject. The registered manager said, "We try to keep it as simple as possible for staff". They complete a questionnaire about MCA". When we asked to see evidence of staff completing this training we were told that staff "take the questionnaires home". When we spoke to staff they told us they had completed some training about MCA and they were able to tell us how they asked people for their consent before completing any personal care support with people. People confirmed this was the case. One person said, "Yes we're involved in decision making and the care planning. They're usually very good, caring and respectful and always ask before they do anything". One staff member described how they approached and tried to appropriately support a lady with a diagnosis of dementia to sensitively encourage her to go for daily walks. The staff member said, "I always ask the person if they'd like to go for a walk. If declined I write down that they've declined. If she says no we try to ask three times, if she declines we document it. I leave it 5 -10 minutes before I ask again".

However, the manager and office staff had limited knowledge of current good practice and understanding of the MCA. There was confusion about current best practice in relation to mental capacity. We were told that some of the people receiving care lacked capacity, however mental capacity assessments had not been completed by the service. The registered manager told us that they "didn't realise" they had to complete MCA assessments and stated that they "thought that social services completed these for people". This presented a risk to those people who may lack capacity and who do not have involvement from the local social services department. We informed the registered manager of the importance of completing MCA assessments when appropriate to do so for people. This ensures that people or relevant others, including those who have Lasting Power of Attorney for Health and Welfare and Financial and Property affairs are able to consent to their care plans appropriately and to ensure that care and treatment is provided in a least restrictive way in people's best interests.

This is a breach of Regulation 11 of the HSCA 2008 (Regulated Activities) Regulations 2014.

The provider did not always deliver person centred care. One example related to staff responding to a person's changing needs. There were concerns that one person was not eating and drinking enough. A food and fluid monitoring form had been introduced. However, there was no guidance in their care plan records on what to do if the person did not eat or drink enough. Food and fluids were therefore not being monitored effectively for this person. We also found that not all staff had completed basic food hygiene training to enable them to be competent to prepare and provide meals to people to meet their nutritional needs effectively and safely. People's preferences were not recorded in their assessment records which meant that people may not be receiving care in their preferred way that they may choose to. This is especially important to those people who may lack the mental capacity to tell people how they would like their care to be provided.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The systems for monitoring staff training were not robust and there were gaps in staff training. The deputy manager told us "each month I go through them [staff training records] to see what training is required". There was no system to effectively monitor the training staff required and the frequency with which they would need to attend refresher training. Following the inspection the registered manager sent us their 'training matrix'. A Training Matrix is a tool that can be used to track training and skill levels within an organisation. A training matrix has a variety of uses from identifying gaps in training and monitoring staff

required and actual knowledge levels and also tracking competency levels. However, the information about the training was conflicting and unclear in terms of the actual frequency that staff were required to complete training and dates of when they had completed training was not included. For example, the 'training matrix' indicated that staff were required to complete basic food hygiene at induction, after one year, two years and three yearly. We did not find evidence of staff completing basic food hygiene training at these intervals. Therefore, staff were not trained in line with the agency's training guidelines.

Staff received training in, moving and handling, infection control, medication and health and safety. Staff training did not include topics relevant to the specific and individual needs of the people receiving a service. One person was living with COPD (chronic obstructive pulmonary disease).Staff did not receive training in this subject to know how to support this person. The office administrative staff member told us that they usually print off some information for staff regarding people's specific needs and add this to the care plan folder. This is not personalised and does not ensure that staff know how to support this person with their individual needs relating to their diagnosed condition. We were told that staff were completing dementia awareness training, but we did not see evidence of this being completed in staff training files. This meant that staff may not understand how to effectively support people with a disability, a sensory loss and communication needs, which are also referred to as "protected characteristics" under the Equality Act 2010. Care plans for people were limited in detail about people's communication needs. One person with a diagnosis of Macular Degeneration and registered as blind care plan stated 'glasses for reading and watching TV', with no further information about the condition itself or how the person was living with the condition and what specific support and understanding they may require from staff supporting them. Staff had not received training to understand people's needs when they are living with sensory loss or communication difficulties.

However, new staff were supported to understand their role through a period of induction. They were required to complete training courses and work towards the Care Certificate. The Care Certificate sets out learning outcomes, competencies and standards of care that care workers are nationally expected to achieve. New staff undertook a period of shadowing when they worked alongside an experienced staff member. The registered manager told us that their progress was reviewed using a 'spot check' process on a frequent basis. This involved the staff member being observed by a more senior member of staff whilst they were undertaking support visits to people in their homes. The registered manager told us that spot checks were carried out to observe all staff practices. We saw records to confirm that spot checks were happening.

The staff spot check and supervision records were not fully completed and did not contain specific details of any actions taken when shortfalls were noted. For example, we saw that a staff member was not wearing their identification badge (ID) on two separate occasions and no action had been taken. It is an expectation of the agency that staff will wear their ID badges when visiting people in their homes. This ensures that people can be confident that the people they allow into their homes work for the agency. One of the spot check records completed for them stated that all areas were competent. However, we were not able to see how the staff member was assessed as being competent when they we not following expected practice by wearing their ID badge. Another supervision record stated how a staff member had chosen not to follow a person's care plan. Again, no follow up action had been taken by the management team to ensure the suitability and appropriateness of the staff members practice.

Staff had some supervision with the registered manager and spot checks from senior staff. However, the records were incomplete. The records did not have the action plan section completed and had not always been signed by the staff members. One staff member told us that they had not received any supervision or spot checks from their supervisor since they started in their role. Despite the fact that staff told us they felt supported by the managers, there was a risk that unsupervised staff and a failure to follow up on

performance issues may result in staff not having the required skills, or the right knowledge and experience to deliver effective care and support to people.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

People's needs relating to equality and diversity were not assessed at the start of the service. Care plans did not always include instructions to staff on what actions they needed to take to meet people's individual cultural needs. Six care plans were not person centred; they did not always contain details of people's backgrounds, social history and information about other people who may be important to them in their lives. This could prevent the agency from scheduling the right staff to visit people based upon the staff abilities to work with different people's individual needs.

We recommend the provider ensures they seek further advice on how to ensure person centred cared is assessed, recorded and delivered and people are involved in this.

People received caring support from the agency. Staff told us they usually visited the same people consistently which enabled them to build and develop positive professional relationships and to know people's needs, preferences and wishes. One person said that they didn't always know when staff would visit their relative. Another person using the service said; "I've got one really good carer who always makes sure she stays the full time. I know what time they're coming". A member of staff told us that they provided consistent care to people. They said; "there's one client I've got that I go to every day, Monday to Friday. She likes that".

People felt that the staff were caring, kind and respectful. One person said that the staff are "very nice people, considerate and helpful. They come once a day to help me shower and put my compression stockings on. They wear gloves and aprons. They respect my privacy and keep me covered". Another person said; "can't fault them, they're very caring. They are very good helpers I can trust them. They're a comfort".

A staff member told us of how they followed the instructions provided by a person's relative. This helped to ensure that they knew how the person living with dementia liked things to be done regarding the care they received from the agency. The staff member said, "her daughter wrote down everything that was needed for her mum". This shows that staff worked with people's representatives to help them to be involved in the care of their relative.

Staff showed that they developed caring relationships with people and were able to describe how they met people's needs in caring ways. One member of staff told us how they responded to the needs of a person who was experiencing pain and discomfort in an appropriate, compassionate and timely way. When we asked them to provide an example, the staff member said, "just like this morning. I spoke to my manager and they got extra calls in place. I also called the doctor as she was in pain. The doctor visited".

People's right to confidentiality was protected. Staff received training in confidentiality in their care certificate induction training. All personal records were kept securely in the office and on the service's computer system, only accessible by authorised staff using equipment owned by the agency.

Requires Improvement

Is the service responsive?

Our findings

People's cultural needs and preferences were not clearly noted in their care plans to enable staff to provide support in their right way for people on a day to day basis but also to ensure that individual needs and choices are upheld and respected at the end of people's lives. People's care and support needs must be assessed in line with the Equality Act 2010 to ensure that services comply with all relevant Legislation. We looked at initial assessments or people. These assessments were limited in content and we did not see sufficient information that the service clearly identified people's communication needs when they may be living with sensory loss. One person had a diagnosis of macular degeneration which is a condition affecting the central vision. There was no personalised information supporting staff to understand what this condition may mean for this person and how it may impact upon their daily lives. From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS).In line with section 250 of the Health and Social Care Act 2012, services must identify, record, flag, share and meet people's information and communication needs. We spoke to the registered manager and deputy manager about their understanding of the AIS. They were not aware of the AIS. This is an area that requires improvement.

The registered manager told us that the service provided care to people at the end of their lives. We spoke with healthcare professionals regarding their views of how the agency supported people at the end of their lives. They told us the agency had responded appropriately to a complaint made earlier in the year and had taken appropriate action to address the concerns raised with them. They had also received two compliments regarding the agency. They told us, "We received two positive friends and family test forms commenting on the agency being professional, friendly and accommodating."

Complaints for people were not recorded or used as an opportunity to learn and to drive continuous improvement within the agency. The agency's complaints folder did not contain evidence of the complaint that we were informed of by the healthcare professional. The registered manager told us that they had not received any complaints. The provider had effectively handled the complaint as stated by the healthcare professional, however, they had not recorded the details of the complaint in their complaints process. The agency did not evidence any records of their responses to or from the complainant so we were not able to see if the complainant was satisfied with the outcome of their complaint and any changes the provider may have made to the service as a result of the feedback.

People told us that they knew how to raise a complaint and that they would be happy to do so should this be required. Most people said they could talk to staff or the agency directly if they had a complaint. One person said; "I know exactly what to do if I've got a complaint, ring the office. If I've got a complaint I'll make sure everyone knows about it". Another person told us that; "I've got no complaints. If I had a complaint I'd ring the office. I'd say, "I've asked you nicely". Then ring the office".

The deputy manager told us that staff received end of life care training. Staff told us how they could contact the office to discuss concerns they may have about a person's changing needs. An example of this was when a person was experiencing pain. The agency arranged for additional visits to be provided to the person to

support them.

Technology was used to support people to receive timely care and support. Care plans for people were stored electronically. Staff were able to access an abbreviated version of a person's care needs using a hand held electronic device provided by the agency. The registered manager told us the devices were password protected to ensure that confidential data held about people was protected and held securely. The full paper based version of people's care records were held in the office with a further copy being kept in people's homes.

Electronic systems were used by the agency to monitor staff visiting people. This ensured that the agency were able to track and monitor the service delivered to people. The system alerted office staff if staff were running late or did not arrive at a location as scheduled. This enabled the agency to contact the person to inform them that the service may be later than expected.

Inadequate

Is the service well-led?

Our findings

There is a registered manager at this service who has been registered with the CQC since April 2013. A registered manager is a person who has registered with the CQC 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.

The agency was previously inspected in October 2015 and the overall rating was Good. However, during this inspection, we found that the registered manager had been unable to sustain this level of good practice. In January 2015 we rated this provider as Inadequate overall, with breaches of eight Regulations Two of these breaches resulted in us taking enforcement action against the provider. We had significant concerns about the quality of service provision and the provider's ability to have clear oversight and regular monitoring of the service. Other concerns related to poor medicines management, lack of detail in people's care plans and risk assessments to mitigate risks to people. Staff were not completing mandatory training and there was a lack of staff supervision and poor management understanding of the Mental Capacity Act 2005 and how this affected their provision of care to people.

In May 2015 we completed a Focused inspection to review the provider's progress against the previous concerns. We found that the provider was still providing an Inadequate service in relation to the assessment of risks and completion of appropriate risk assessments for people. People's medicines were still not being managed safely. There had been some improvements in the provider's quality systems and it was noted that medicines audits were being completed by the registered manager. Despite the service being rated as good overall in October 2015, in November 2017 we found that this had not been sustained. The registered manager was not completing any audits to monitor the quality and safety of the service provided to people.

At this inspection we found the registered manager did not always fully understand their role and responsibilities and we had significant concerns about the day to day management of the service.

The CQC had not received statutory notifications from the registered manager for incidents that should have been reported to us. These notifiable incidents included; death, safeguarding people from abuse and any incidents involving the police. We saw evidence during the inspection that nine safeguarding incidents had taken place since the previous inspection and we were not notified of them. This is a registration requirement of the CQC which enables us to effectively monitor the service, ensuring that the required measures are undertaken by all regulated providers. However, the registered manager was not aware of their responsibilities under the legislation that states that all significant events including safeguarding concerns are notified to the Care Quality Commission without delay. We use this information to monitor the service and ensure they respond appropriately to each incident to keep people safe. At the time of the inspection we had not received any statutory notifications for people using the service. During the course of the inspection we saw records that showed there had been seven cases of safeguarding throughout 2017. Other significant incidents which we require the registered person to notify us of in Law, had also not been reported to us. The registered manager was not clear of their role with regards to notifying us of events and

incidents.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

However, the registered manager was able to show us that they had referred safeguarding concerns appropriately to other agencies. We saw evidence of the agency working with social services to highlight and resolve any safeguarding concerns that were raised by the agency.

There was a lack of robust management and leadership. Audit and quality assurance systems had not been effective in identifying and addressing problems. We found shortfalls in the service that the registered manager had not identified. For example there were shortfalls in staff knowledge and application of the Mental Capacity Act 2005. The lack of any formalised audit system meant that the registered manager had no oversight of the issues identified. This included incomplete and inaccurate records. Care plans had not been audited for accuracy and gaps in staff training and supervision records were identified. This meant that the agency weren't following their policies and procedures. The provider did not have a robust or effective system to monitor and improve the quality and safety of the service.

Complaints were not recorded or used to monitor the effectiveness of the service delivered. We could not see clear evidence of the learning or changes to procedures or practices from listening to people's views or from incidents or accidents that may have occurred due to the lack of effective systems and processes to monitor the quality and safety of the service provided. The registered manager did not fully understand their duties under the Duty of Candour regulation when asked about this. We could not be assured that an open and transparent service was always provided to people using the service when things go wrong. We looked at the Provider Information Return (PIR) received from the agency before this inspection, which describes the service they provide. The PIR did not refer to how the service manages complaints or end of life care for people. This is an area that requires improvement

We reviewed the Provider Information Return (PIR) received from the provider before this inspection. Within the PIR the provider stated that "the company has a number of tools to monitor the service." The PIR also states "all mandatory training is updated on a regular basis". We did not see 'tools' to monitor the service during the inspection and mandatory staff training was not up to date. In the section of the PIR that asks the provider how they assure themselves about the quality of care practice, there is limited information describing how the provider has robust systems and processes to monitor the overall quality of the service. This means that the registered manager has not ensured that quality is an integral part of the service provided. The registered manager confirmed that they do not currently complete any audits to monitor the quality of the service provided and there is no service wide action plan to enable the agency to effectively monitor any improvements that may be required.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were some mixed views from people who used the service and their relatives, regarding the management of the agency. People using the service told us that; "the office I wouldn't say it deliberately slips, but because they are very busy they can't keep up". A persons relative said; "the office isn't always as efficient as it could be. But usually well managed".

Some people told us that they had been asked for feedback on the service provided. We saw records which showed that people were mostly satisfied with their care in an analysis report completed by the registered

manager of the satisfaction survey responses received. When issues had been raised by people, the registered manager said these had been addressed. However, we saw limited documentation to confirm the outcomes for people and there were no action plans developed to address and monitor any shortfalls to the service.

Staff told us that they felt supported by the management team and that they were listened to. Staff said that the management team made changes when things went wrong. We saw evidence of emails and information that had been shared with the staff electronically, using a secure process following an incident that had happened. One example of this was an email reminding staff of the importance of not accepting gifts from people and reiterating the agencies policy of staff recording gifts received in a log book held at the office. We were shown evidence of staff reporting gifts from people using the correct procedure during the inspection. Records of staff meetings were seen and staff told us they had been invited to attend staff meetings.

The agency works in partnership with a number of other external agencies including the local social services department and fire service. Information is shared with these external agencies for people who use the service.

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 11 HSCA RA Regulations 2014 Need for consent Lack of MCA awareness and no evidence of MCA assessments in records for people

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Insufficient risk assessments or preventative strategies to provide safe care and treatment to people

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Lack of supervision and spot checks consistently for staff. Lack of mandatory training

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 Lack of governance and oversight across the agency. no audits in existence. lack of Duty of Candour understanding. No statutory notifications sent to CQC

The enforcement action we took:

not yet completed